



Physician Injectable Drug List (PIDL) Review Request Form

The request to consider coverage of additional injectables or changes to existing injectable drugs will be completed in the order received. The goal is to complete the review and respond to requests within 30 days of receipt of the completed form. For detailed information regarding the PIDL policy refer to Part II Policy and Procedure Manual for the PIDL. All Medicaid policy manuals for the Georgia Department of Community Health (DCH) are accessible online at www.mmis.georgia.gov; click on the "Provider Information" tab; then the "Medicaid Provider Manuals" link.

Request Date: _____

REQUESTOR CONTACT INFORMATION

Provider Name & Number: _____ **Name of office Contact:** _____

Practice/Company Name: _____

Address: _____ **City, State Zip** _____

Phone: _____ **FAX:** _____ **Email:** _____

REQUEST

Request consideration to: Open new injectable drug Chg or add new indication(s) to already approved drug

Chemical Name: _____ **Brand Name:** _____

HCP/CS/CPT Code(s): _____ **Dose/Unit:** _____

NDC(S): _____ **AWP/Unit:** _____

Does the manufacturer offer rebates on the drug at this time? Yes No

Approved Indications(s): _____ **ICD10 Code(s)** _____

FDA Approval Date: _____ **If not FDA approved, date application submitted?** _____

Is there a specific Medicaid eligible patient pending this determination? Yes No

If yes, please indicate patient's name and Medicaid ID# _____

Briefly summarize your request in the space provided below and attach any supporting documentation

you wish to be considered: _____

Submit completed request electronically to: pjeter@dch.ga.gov

for receipt by:
Medical Policy Unit/PIDL Review
Georgia Department of Community Health

DCH USE ONLY

PBM Consulted (Y/N) _____
Approved/Denied _____
Maximum Allowable _____
Maximum Units _____
PA Required (Y/N) _____
Effective Date _____
Requestor Notified (Y/N) _____
Date Review Completed _____

Comments:



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Reviewer Initials _____
