PAUL R. LEPAGE
GOVERNOR

Maine Department of Health and Human Services
MaineCare Services
Pharmacy Unit
11 State House Station
Augusta, Maine 04333-0011

BETHANY L. HAMM
ACTING COMMISSIONER

Date____/____/____

Member Name (print): _____
Member ID#: _____
Pharmacy NAPB: _____
Pharmacy NPI: _____
Prescriber Name: _____
Prescriber DEA#: _____

Medication Needing PA: _____
Quantity Requested: _____Days Supply: _____
Amount Paid: _____

Some medications or quantities of medication require Prior Authorization by the Department. This means additional information is needed from the prescriber. If the medication meets MaineCare criteria, the Department will approve the request. The member will be charged a MaineCare co-payment for the medication.

By signing below, you indicate that you understand the following:

- You have been informed that the medication requires Prior Authorization by the Department
- You have chosen not to request Prior Authorization through the pharmacy or the prescriber
- In order to receive this medication without the Department's Prior Authorization, you will have to pay the usual and customary price of this medication.

Member Signature: _____

Pharmacy Representative Signature: _____

Please fax completed form to Change Healthcare at 1-800-408-1088