LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

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DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Medical Standards Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

December 13, 2005

MEMORANDUM ACS M05-11

TO: Nursing Facilities and Physicians

FROM: Angie Payne, Acting Med-QUEST Division Administrator

SUBJECT: MANAGEMENT OF NURSING FACILITY (NF) RESIDENTS WHO REQUIRE PSYCHOTROPIC MEDICATIONS

Senate Bill (SB) 1420 concerning psychotropic medications became law effective July 1, 2005. This law states that licensed psychiatrists are able to prescribe psychotropic medications to Medicaid recipients without prior authorization. Also, prior authorization is not required for licensed physicians who prescribe psychotropic medications in consultation with licensed psychiatrists.

In compliance with SB 1420, the MQD will cover NF visits performed by psychiatrists for pharmacologic management of psychotropic medications so that the "no prior authorization" policy for psychotropic medications can be applied to individuals residing in nursing facilities.

The psychiatrist should use the code 90862 (pharmacologic management) for the evaluation, prescription, titration, etc., of psychotropic medications. If an evaluation and management service is provided in the NF by the psychiatrist to initiate treatment with psychotropic medications and/or assess and monitor the effectiveness of treatment, Medicaid will cover the appropriate NF visit code in the range of 99311 to 99313. Psychotherapy will remain non-covered when provided in a NF.

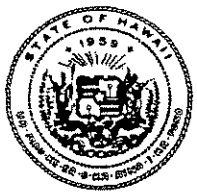
Prior authorization is required for atypical antipsychotic agents prescribed by licensed physicians who have NOT consulted with a psychiatrist. Attached is ACS Memorandum P03-01, dated January 10, 2003, page 3 that details the requirements for an expedited authorization by non-psychiatrists for low doses of atypical antipsychotic agents and the forms and procedures for obtaining higher doses of atypical antipsychotic agents.

Coverage of 90862 and the appropriate code for evaluation and management in an NF are effective upon receipt of this memorandum for NF residents currently covered under Medicaid's drug coverage. Beginning January 1, 2006, when Medicare Part D goes into effect, Medicaid coverage of 90862 and the NF evaluation and management service for psychiatrists ONLY apply to NF residents whose primary insurer is Medicaid and who DO NOT have Medicare Part D coverage.

Attachment

LINDA LINGLE
GOVERNOR

PATRICIA MURAKAMI
ACTING DIRECTOR



STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Medical Standards Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

January 10, 2003

MEMORANDUM

P03-01

TO: Medicaid Physicians, Dentists, Other Providers with Prescribing Authority and Pharmacy Providers

FROM: Aileen Hiramatsu, Med-QUEST Division Administrator

SUBJECTS: **FEE-FOR-SERVICE PROGRAM ONLY**

1. All OxyContin® Claims
2. Maximum Standard Doses
3. Plan Summary Descriptions on the Website
4. Prior Authorization for Eloxatin®
5. Prior Authorization for Lotronex®
6. Prior Authorization for Zelnorm®
7. Modified Prior Authorization for Low Dose Atypical Antipsychotics - **CORRECTIONS**
8. Prior Authorization for Low Dose Atypical Antipsychotics (Abbreviated Format)
9. Prior Authorization for OxyContin® (Abbreviated Format)

1. All OxyContin® (Oxycodone Hydrochloride) Claims

The diagnosis for OxyContin® must be submitted on each claim for OxyContin® regardless of the daily dose.

2. Maximum Standard Doses – Effective February 14, 2003

After review of Medicaid program limits in other states, product literature, and Food and Drug Administration (FDA) recommendations, maximum standard doses will be implemented effective ***February 14, 2003*** for the attached list of drugs and strengths. These will also be

posted on the website at www.himed-questffs.org, under the heading of DRUG COVERAGE, as Maximum Standard Doses. As needed, other drugs, strengths and doses will be posted. For those that cannot access the website, a list can be requested from the Affiliated Computer Services (ACS)/Pharmacy Benefits Manager (PBM) Help Desk by calling 1 (877) 439-0803. The request will be escalated and provided usually by the next business day.

Medically necessary doses beyond these standards will be considered by the usual prior authorization process with the documentation of safety and efficacy of the requested doses.

3. **Plan Summary Descriptions**

Posted on the website, www.himed-questffs.org, are the plan summary descriptions (Plan 100, 200, 300, etc.) for eligibility coverage as defined within the ACS database and referred to by the ACS/PBM Help Desk. These are ACS descriptions of Med-QUEST pharmacy benefit categories. A list of the plan summary descriptions can be requested from the ACS/PBM Help Desk by calling 1 (877) 439-0803 for those that cannot access the website.

4. **Prior Authorization (PA) for Eloxatin® (Oxaliplatin) – Effective February 14, 2003**

Indication:

In combination with infusional 5-fluorouracil (5-FU)/leucovorin (LV) for the treatment of patients with metastatic carcinoma of the colon or rectum whose disease has recurred or progressed during or within six months of completion of the first-line therapy with the combination of bolus 5-FU/LV and irinotecan (Camptosar®).

PA Requirements:

- Documentation of the diagnosis and medical necessity.
- Must be used with 5-FU/LV and irinotecan (Camptosar®).
- Documented disease has recurred or progressed during or within six months of completion of the first-line therapy with the combination of bolus 5-FU/LV and irinotecan.

5. **Prior Authorization for Lotronex® (Alosetron Hydrochloride) – Effective February 14, 2003**

Indications:

Treatment of women with severe diarrhea-predominant irritable bowel syndrome (IBS), who have failed to respond to conventional therapy, whose IBS symptoms are chronic (generally lasting six months or longer), and who have had other gastrointestinal medical conditions ruled out, which could have explained their symptoms.

PA requirements:

- **Female patients only.**
- At least 18 years of age.
- A documented diagnosis of IBS with **predominant severe diarrhea** and have the following:

  a. Failed to respond to conventional therapy; and

b. IBS symptoms (**diarrhea predominant**) are chronic (generally lasting six months or longer).

If approved, the following will apply:

- Maximum allowable quantity is **30 tablets for the first month** and up to **60 tablets per month thereafter**.
- Initial approval is for up to **three months only**.
- Continued coverage requires documentation that the patient is responding to therapy. The authorization period will be up to an **additional three months**.

6. Prior Authorization for Zelnorm® (Tegaserod) – Effective February 14, 2003

Indications:

The short-term treatment of women with IBS whose primary bowel symptom is constipation.

PA requirements:

- **Female patients only.**
- A documented **diagnosis of IBS** with primary bowel symptom of **constipation.**

If approved, the following will apply:

- Maximum allowable quantity is **60 tablets per month.**
- Initial approval is for up to **two months only.**
- Continued coverage requires documentation that the patient is responding to therapy. The authorization period will be up to an **additional two months.**

7. Modified Prior Authorization for Low Dose Atypical Antipsychotics - CORRECTIONS

Please note the **corrections** in the following maximum daily doses of Olanzapine as *5 mg/day* and Quetiapine as *100 mg/day*. They are posted correctly on the website at www.himed-questffs.org.

Atypical Antipsychotic	Maximum Daily Dose	Suggested Starting Dose
Risperidone (Risperdal®)	1 mg/day	0.25 – 0.5 mg/d
Olanzapine (Zyprexa®)	5 mg/day*	2.5 mg/d
Quetiapine (Seroquel®)	100 mg/day*	12.5 mg/d

*Corrections

These were incorrectly stated in the provider memorandum, ACS Pha-13/ACS Pres-13, dated October 18, 2002.

8. Prior Authorization for Low Dose Atypical Antipsychotics (Abbreviated Format)

Modified PA criteria (without the previously required consultation of a psychiatrist) for atypical antipsychotics in elderly patients with specific behavioral symptoms require all of the following:

a. Patient age 65 years or older.

b. Patient has symptoms consistent with the following ICD-9 Codes:

780.09	Delirium, Not otherwise specified (NOS)
780.1	Hallucination, NOS
297.1	Paranoia
294.11, 331.0	Alzheimer's Dementia with Behavioral Disturbance
290.40, 437.0	Arteriosclerotic Dementia with Psychosis, NOS
290.12	Presenile Dementia with Delusions
290.2	Senile Dementia with Delusions, Paranoid Type

c. Proposed use of one of the following atypical antipsychotics, not exceeding the maximum daily doses listed below. (General guidelines for suggested starting doses are also noted below.)

Atypical Antipsychotic	Maximum Daily Dose	Suggested Starting Dose
Risperidone (Risperdal®)	1 mg/day	0.25 – 0.5 mg/d
Olanzapine (Zyprexa®)	5 mg/day	2.5 mg/d
Quetiapine (Seroquel®)	100 mg/day	12.5 mg/d

Initial and subsequent modified PA turn around time and approval period:

a. Review of the initial PA will be done within 24 hours (one working day).

b. The initial PA will be effective for 90 days (three months).

c. A subsequent PA can be submitted, after the patient has been re-evaluated for continued need of these agents, for approval and would be effective for a period of 12 months.

Reminder:

For doses in excess of these maximum daily doses, a PA with a Brief Psychiatric Rating Scale (BPRS) report and form DHS 1162 are required, if prescriber is not a Medicaid provider with a specialty in psychiatry. These forms are in the provider manual's compact disc (CD) and at the website www.medquest.us.

9. Prior Authorization for OxyContin® (Oxycodone Hydrochloride), (Abbreviated Format)

Authorization requests for use in chronic non-cancer pain for daily dosage exceeding 160 mg require all of the following:

a. Patient must be at least 18 years old.

b. Patient must not be pregnant.

c. Diagnosis must be provided.

d. Strength and total daily dosage must be provided.

e. Documentation of the failure or non-tolerance of at least one other long acting opioid analgesic.

f. Acceptable reasons for a dosage greater than 160 mg per day include:

- Patient has severe, chronic pain and has been referred to a pain specialist. If being seen by a pain specialist, the name of the pain specialist and the plan of care must be attached.
- The patient is currently physically dependent. A plan of care for the treatment must be attached.

g. No early refills will be allowed.

Authorization requests for patients with pain related to systemic cancer for total daily doses exceeding 160 mg prescribed by non-oncologists:

a. Diagnosis must be provided.

b. Strength and total daily dosage must be provided.

c. PA is required for early refills for dose adjustments, lost or stolen medications.

No authorization requirement for over 160 mg per day:

a. Authorization for patients with pain related to systemic cancer will NOT be required if:

- The physician is a Medicaid provider with a specialty in oncology;
- The patient has systemic cancer;
- His/her pain is directly related to the cancer.

b. Oncologist must provide the pharmacy with the International Classification of Diseases, 9th Edition (ICD-9) diagnosis.

c. PA is required for early refills due to dose adjustments, lost or stolen medications.

Approval Period:

a. For chronic non-cancer pain:

- The initial authorization period will be a maximum of three months.
- For subsequent requests for the same or greater dosages, justification and a plan of care must be submitted.

b. For pain related to systemic cancer, the authorization period will be a maximum of six months.

Pharmacy Requirements:

The pharmacy must provide:

- The National Drug Code (NDC) numbers of the OxyContin® strength(s) requested by the physician on the authorization form.
- The pharmacy must include the ICD-9 Diagnosis code provided by the physician, on each billing claim.

If you have any questions, please contact Ms. Lynn Donovan, Med-QUEST Division pharmacy consultant, at (808) 692-8116. Questions may be faxed to (808) 692-8131.

Arlene Hamamoto
Med-QUEST Division Administrator

Attachment

Hawaii Medicaid Fee-For-Service
Maximum Standard Dose

DRUG NAME	STRENGTH	DETERMINATION
Amerge	1 mg Tablet	9 tablets per month
	2.5 mg Tablet	9 tablets per month
Axert	6.25 mg Tablet	6 tablets per month
	12.5 mg Tablet	6 tablets per month
Diflucan	50 mg Tablet	60 tablets per month
	100 mg Tablet	60 tablets per month
	150mg Tablet	2 tablets per month
	200mg Tablet	60 tablets per month
Frova	2.5 mg Tablet	9 tablets per month
Herceptin	440 mg Vial	3 vials per month
Imitrex	25 mg Tablet	9 tablets per month
	50 mg Tablet	9 tablets per month
	100 mg Tablet	9 tablets per month
	6MG/0.5ML Syringe Kit	2 kits (4 syringes) per month
	6MG/0.5ML Refill Kit	2 kits (4 syringes) per month
	6MG/0.5ML Vial	2 vials per month
	Nasal Spray 5 mg	6 nasal spray devices per month
	Nasal Spray 20mg	6 nasal spray devices per month
Maxalt	5 mg Tablet	6 tablets per month
	10 mg Tablet	6 tablets per month
	MLT 5 mg Tablet	6 tablets per month
	MLT 10 mg Tablet	6 tablets per month
Pulmicort Turbuhaler	200 mcg Canister	2 canisters per month
Sporanox	100 mg Capsule	120 capsules per month
Zofran	4 mg Tablet	12 tablets per month
	8 mg Tablet	12 tablets per month
	24 mg Tablet	2 tablets per month
	ODT 4 mg Tablet	12 tablets per month
	ODT 8 mg Tablet	12 tablets per month
	4 mg/5ml Oral Solution	150 ml per month
Zomig	2.5 mg Tablet	6 tablets per month
	5 mg Tablet	6 tablets per month
	ZMT 2.5 mg Tablet	6 tablets per month
	ZMT 5 mg Tablet	6 tablets per month

USE OF CLOZAPINE, OLANZAPINE, RISPERIDONE, QUETIAPINE AND ZIPRASIDONE

(Circle One)

I. CRITERIA

A. For Olanzapine, Risperidone, Quetiapine and Ziprasidone
   1. The patient is actively symptomatic with positive and/or negative schizophrenic symptoms.
   2. The patient is functionally disabled.
   3. The patient is participating in appropriate concomitant treatment and rehabilitation.
   4. The patient has been treated for a reasonable period of time with at least two different classes of neuroleptics without satisfactory results, or is unable to be treated with neuroleptic medications due to severe adverse effects.

B. For Clozapine (for Schizophrenia)
   1. The patient has been treated with Olanzapine, Risperidone or Quetiapine for a reasonable period of time without satisfactory results or has severe adverse effects from them.

C. For Clozapine (for movement disorders)
   1. The patient is actively symptomatic with dyskinesia(s).
   2. The patient has been treated for a reasonable period of time with two different antitremor medications without satisfactory results, or is unable to be treated with antitremor medications due to severe adverse effects.

II. PATIENT DATA (Every item must be completed, use 'None' or 'N/A' if not applicable)

_____ DOB_____/_____/_____ Sex_____M _____F
(Last Name, First Name)

_____ Diagnosis : _____ DSM-IV Code: ____ ____ ____ . ____ ____
(Medical ID #)

How long have you treated this patient?_____

Name(s) of previous psychiatrist(s)/neurologist(s)_____

_____

Describe patient's positive schizophrenic or movement disorder symptoms:_____

_____

Describe patient's negative schizophrenic symptoms:_____

_____

List patient's previous antipsychotic or antitremor medication(s):

NAME OF MEDICATION	DOSAGE/FREQUENCY	DATE USED:
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____

Have symptoms of Tardive Dyskinesia ever been present? _____Yes _____No

Psychiatric hospitalizations within the past five years:

HOSPITAL	LOCATION	DATE
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____

III. PROCEDURES:

A. The following forms and information shall be submitted:

1. DHS 1144 Request For Prior Medical Authorization

2. DHS 1162 Revised 03/01

3. Brief Psychiatric Rating Scale (BPRS) report (Not required for movement disorders)

FAX all completed forms to:

ACS
PA Desk
Fax number: 1-888-335-8474

B. Brief Psychiatric Rating Scale (BPRS) reports are required with every DHS 1162 that is submitted (Not required for movement disorders). When the BPRS is stable (little or no change from last report), a narrative report (indicating that the patient is stabilized and reason(s) for continuing the medication) must be submitted in lieu of the BPRS.

C. The use of Clozapine, Olanzapine, Risperidone, Quetiapine or Ziprasidone may be suspended if the patient has not improved or for other good reason(s).

I certify that the above information is true and will carefully monitor the patient's condition.

_____ _____ _____
(Physician's Signature) (Type or print Physician's Name) Date

(For Consultant's Use Only)

Approved _____ Denied _____

_____ _____
Consultant's Signature Date

NAME _____

DATE:

BRIEF PSYCHIATRIC RATING SCALE

Place the number which best describes the patient's condition in the column to right of statement
NOTE: 1 Not Present; 2 Very Mild; 3 Mild; 4 Moderate; 5 Moderate/Severe; 6 Severe; 7 Extremely Severe

TOPIC	DESCRIPTION	RATING
1. Somatic Concern	Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have a realistic basis or not.	
2. Anxiety (Subjective)	Worry, fear or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanism.	
3. Emotional Withdrawal	Deficiency in relating to the interviewer and to the interview situation. Rate only the degree to which the patient gives the impression of failing to be in emotional contact with other people.	
4. Conceptual Disorganization	Degree to which the thought processes are confused, disconnected or disorganized. Rate on the basis of integration of the verbal products of the patient, do not rate on the basis of patient's subjective impression o f his level of functioning.	
5. Guilt Feelings	Over-Concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidence by verbal report with appropriate affect, do not infer guilt feelings from depression, anxiety or neurotic defenses.	
6. Tension (Objective)	Physical and motor manifestations of tension "nervousness" and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experiences of tension reported by the patient.	
7. Mannerism and Posturing	Unusual and unnatural motor behavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements, do not rate simple heightened motor activity here.	
8. Grandiosity	Exaggerated self-opinion, convictions of unusual ability of powers. Rate only on the basis of patient's statements about himself or self-in-relation-to others not on the basis of his demeanor in the interview situation.	
9. Depressive Mood	Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints.	
10. Hostility	Animosity, contempt, belligerence disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward other, do not infer hostility from neurotic defenses, anxiety nor somatic complaints. (Rate attitude toward interviewer under "uncooperativeness")	
11. Suspiciousness	Belief (delusional or otherwise) that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicious which are currently held whether they concern past or present circumstances.	
12. Hallucinatory Behavior	Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery process of normal people.	
13. Motor Retardation	Reduction of energy level evidenced in slowed movements. Rate on the basis of observed behavior of the patient only, do not rate on basis of patient's subjective impression of own energy level.	
14. Uncooperativeness	Evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interview. Rate only on the basis of the patient's attitude and responses to the interviewer and the interview situations, do not rate on basis of reported resentment or uncooperativeness outside the interview situation.	
15. Unusual Thought Content	Unusual, odd, strange, or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of thought process.	
16. Blunted Affect	Reduced emotional tone, apparent lack of normal feeling or involvement.	
17. Excitement	Heightened emotional tone, agitation, increased reactivity.	
18. Disorientation	Confusion or lack of proper association for person place or time.	

INSTRUCTIONS

DHS 1162

USE OF CLOZAPINE, OLANZAPINE, RISPERIDONE, QUETIAPINE AND ZIPRASIDONE

PURPOSE:

DHS 1162 is an authorization form requesting the use of Clozapine, Olanzapine, Risperidone Quetiapine and Ziprasidone for patients who are Medicaid recipients.

GENERAL INSTRUCTIONS:

The conditions under Part I, Criteria must be met for all patients for whom a request for the above medications is made.

Part II, Patient Data, is to be filled out by the physician.

Part III, Procedures. The steps to obtain DHS authorization and compliance with progress reporting are specified.

DISTRIBUTION:

Original – ACS PA Desk
Approved Copy – Provider
Approved Copy – MQD/MSB File

INSTRUCTIONS

DHS 1144B

HAWAII STATE MEDICAID FEE FOR SERVICE PROGRAM

REQUEST FOR MEDICAL AUTHORIZATION

1. **Medicaid ID Number :** Enter the Medicaid ID.
2. **Patient's Name:** Enter the patient's name (last, first, MI).
3. **Gender:** Check the patient's gender.
4. **Date of Birth:** Enter the member's date of birth: mm/dd/yyyy.
5. **Medicare Coverage:** Check whether the patient has Medicare coverage and is receiving Medicare Home Health Benefits.
6. **Currently At:** Check where the patient is currently located and enter the mailing address.
7. **Expanded Early & Periodic Screening Diagnosis & Treatment (EPSDT):** Check whether the patient has received expanded early and periodic screening diagnosis & treatment.
8. **NDC Number or Drug Name, Strength, Units, or Global Code, or HCPCS:** Enter the NDC Number, Drug Code, or HCPCS code.
9. **QTY:** Enter the quantity.
10. **Purchase Price:** Enter the purchase price.
11. **Rent/Repair:** Circle whether this request is for rent or repair and enter the amount.
12. **Period Requested:** Enter the Period Requested From: and To:.
13. **Diagnosis or ICD-9 code:** Enter the diagnosis code or the ICD-9 code.
14. **BMI (for anorexiants):** Enter the BMI.
15. **Period Requested:** Enter the period requested.
16. **Prognosis:** Enter the prognosis.
17. **Justification:** Enter the justification and include any history of previous treatment. Check if any attachments are included.
18. **Print Physician's Name / Mailing Address:** Print the physicians name and mailing address.
19. **Physician's Signature:** Physicians: Sign the form.
20. **DEA# or Medicaid Provider #:** Enter the physician DEA number or the Medicaid Provider number.
21. **Date:** Enter the date of signature.
22. **Telephone #:** Enter the physician's telephone number.
23. **Fax #:** Enter the physician's fax number.
24. **Contact Name:** Enter the name of the person to contact.
25. **Print Supplier's Name / Mailing Address:** Print the supplier's name and mailing address.
    Suppliers
26. **Comments:** Enter any comments.
27. **Contact Name:** Enter the name of the person to contact.
28. **Telephone #:** Enter the supplier's telephone number.
29. **Fax#:** Enter the supplier's fax number.
30. **Supplier's Signature:** Sign the request.
31. **NABP#:** Enter the NSBP number.
32. **Date:** Enter the date of signature.

Department of H[redacted] Services
Med-QUEST Divis[redacted]

365 [redacted]idge Rd, Suite 400
Atlanta, GA 30350

REQUEST FOR MEDICAL AUTHORIZATION

Check only One – Different Types of Services Must Be Requested on Separate 1144B Forms. [ ] Home Infusion PA [ ] Non-home infusion (Medication only) PA

NOTE: INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS. Approval of this request is not an authorization for payment or an approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of service being certified by Medicaid. The provider of service must verify patient eligibility at the time the service is rendered. Authorization expires 60 days from date of approval unless otherwise noted by the consultant.

[1] Medicaid ID Number	[2] Patient's Name (Last, First, M.I.)	[3] Gender [ ] M [ ] F	[4] Date of Birth / /
[5] Medicare Coverage? [ ] Yes [ ] No Is Patient receiving Medicare Home Health Benefits? [ ] Yes [ ] No	[6] Currently at: [ ] Home [ ] Hospital [ ] SNF/ICF/ICF-MR Facility Patient's Mailing Address (St., City, Zip Code)	[7] Expanded Early & Periodic Screening Diagnosis & Treatment (EPSDT): [ ] Yes [ ] No	

Physician Section			Supplier Section (Circle Rent or Repair)			
	[8] NDC Number or Drug Name, Strength, Units, Global Code, or HCPCS code	[9] QTY	[10] Purchase Price	[11] Rent/Repair	[12] Period Requested From:	To:
1						
2						
3						
4						
5						

Physician Section

[13] Diagnosis or ICD-9 code

[14] BMI (for anorexiants):

[15] Period Requested

[16] Prognosis

[17] Justification (include history of previous treatment) ([ ] Attachment)

[18] Print Physician's Name/Mailing Address

[19] Physician's Signature

[20] DEA or Medicaid Provider #

[21] Date

[22] Telephone #

[23] Fax #

[24] Contact Name

Supplier Section

[25] Print Supplier's Name/Mailing Address

[26] Comments

[27] Contact Name

[28] Telephone #

[29] Fax #

[30] Supplier's Signature

[31] NABP #

[32] Date

DHS 1144B (08/02)