Discharge Medication Request for Pharmacy Authorization

Please fill out the form below and return by FAX to: 1-866-925-3006 — **ATTN:** Pharmacy Department

Member First Name: _____ **Member Last Name:** _____

Member Medicaid Number: _____ **Member DOB:** MONTH _____ DAY _____ YEAR _____

Member Discharged From (Hospital/Facility): _____

Facility Contact Person: _____ **Facility Phone Number:** _____

Discharge Medication Information:		
Rx DRUG NAME	**DRUG STRENGTH**	**DIRECTIONS FOR DRUG USE**
Prescriber Name:		
Prescriber NPI:		
Please fill out pharmacy information below (if known):		
Pharmacy Name:		
Pharmacy Location:		
Pharmacy Phone Number:		
Additional Notes or Instructions:		

LouisianaHealthConnect.com