CLAIMS AUTHORIZATION REQUEST FORM
Colorado State Drug Assistance Program - ADAP

Provider Services: 888-311-7685
Fax Form to: 800-848-4241
or 510-587-2799

PLEASE REVIEW REQUEST FOR ACCURACY AND COMPLETE ALL APPROPRIATE FIELDS.

PHARMACY INFORMATION

NPI: _____

Contact Person: _____

Stamp or Write: Pharmacy Name, Phone & Fax

PHONE: (_____) _____
FAX: (_____) _____

CLIENT INFORMATION
(Print Clearly)

_____
Last Name First Name

I.D.: _____

D.O.B. _____ / _____ / _____

MUST CHECK ALL THAT APPLY
PROOF OF BILLING MUST ACCOMPANY THIS REQUEST

Program Limits
- ☐ Program/Plan Max Exceeded $ _____
- ☐ Prescription Cost Exceeds Max $_____
- ☐ Refill Too Soon
- ☐ Claim Too Old

Plan Limits
- ☐ Fills Per Year Exceeded
- ☐ Fills Per Prescription _____
- ☐ Days Supply Greater Than Maximum
- ☐ DHHS ARV Daily Dosing Limits**
- ☐ DHHS ARV Duplicate Therapy**
- ☐ DHHS ARV Drugs/Components Not Recommended**
- ☐ Max Day Supply At Retail Exceeded _____
- ☐ Early Refill Due To *(Circle applicable exception):* Lost / Vacation / Stolen

Formulary and Billing Exceptions
- ☐ Brand Dispensing Exception **
- ☐ PSC/DAW Exception ____
- ☐ Other Coverage Code (OCC) Exception ____
- ☐ Compounds

*** Submit rationale for authorization of therapy not recommended OR dispensing not allowed in the exception explanation section below.*

Prescription Details						Copay	Qty	Day Supply	OCC	Date of Fill
RX#1 _____	NDC: _____	-	_____	-	___	$_____		_____		_____
RX#2 _____	NDC: _____	-	_____	-	___	$_____		_____		_____
RX#3 _____	NDC: _____	-	_____	-	___	$_____		_____		_____
RX#4 _____	NDC: _____	-	_____	-	___	$_____		_____		_____
RX#5 _____	NDC: _____	-	_____	-	___	$_____		_____		_____
RX#6 _____	NDC: _____	-	_____	-	___	$_____		_____		_____

Exception Explanation:

All Claims over 45 days for HMAP/JAIL, 90 days for HIAP/SWAP, & 180 days for SPAP will be denied.