

# Physician Injectable Drug List (PIDL) Review Request Form

SUBMIT FORM

PRINT 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](http://www.mmis.georgia.gov); click on the "Provider Information" tab; then the "Medicaid Provider Manuals" link.

**Request Date:** \_\_\_\_\_

**REQUESTOR CONTACT INFORMATION**

**Provider Name &** \_\_\_\_\_ **Name of office Contact:** \_\_\_\_\_

**Number:** \_\_\_\_\_

**Practice/Company Name:** \_\_\_\_\_

\_\_\_\_\_ **City, State Zip** \_\_\_\_\_

**Address:** \_\_\_\_\_ **FAX:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**REQUEST**

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

**Chemical Name:** \_\_\_\_\_ **Brand Name:** \_\_\_\_\_

**HCPCS/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):** \_\_\_\_\_ **ICD-10 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](mailto: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:**