



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

**Rifampin and Tuberculosis (TB) Products
Prior Authorization Request Form**

Beneficiary Name: _____

Beneficiary Medicaid ID #: _____ Date Of Birth: ____/____/____

Pharmacy Name: _____

Pharmacy Medicaid ID#: _____ Pharmacy NPI#: _____

Phone Number: (____) _____ Fax Number: (____) _____

Drug Name: _____ NDC Requested: _____

Prescribing Physician's Name: _____

Physician Medicaid ID#: _____ Physician NPI#: _____

Phone Number: (____) _____ Fax Number: (____) _____

1. Please indicate the diagnosis for which the Rifampin and Tuberculosis medication is being prescribed (no dx codes):

Prescribing Physician's Signature: _____ Date: ____/____/____

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**