



**FLORIDA DEPARTMENT OF HEALTH**  
Prescription Program Authorization

Plan Name: **FLORIDA DEPARTMENT OF HEALTH**

Eligible Client/Patient: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Authorization Signature: \_\_\_\_\_

Walgreens Input Code: **FDFL**

**\*PHARMACY STAFF PLEASE NOTE:**

**This authorization is for the attached prescription only**  
**Quantity Limitations – 42 day supply**  
**Drug coverage is per Rx form and only applies to Viamune and Zidovudine**  
**or Retrovir syrup**  
**Please file this authorization form with the prescription**  
**\*NO REFILLS ALLOWED**