
# FLORIDA DEPARTMENT OF HEALTH

Prescription Program Authorization

Plan Name: **FLORIDA DEPARTMENT OF HEALTH**

Eligible Client/Patient:_____

Date of Service:_____

Medication/Quantity:_____

Prescribing Physician:_____

Authorization Signature:_____

Pharmacy Input Code:_____

**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 Viramune, Zidovudine, Lamivudine, Epivir, Nevirpine, Raltegravir or Retrovir syrup**
**Please file this authorization form with the prescription**
**Voucher must be submitted to Baby RxPress monthly**
**NO REFILLS ALLOWED**