



Pharmacy Benefit Prior Authorization Request Form

Pharmacy Fax: 866-930-0019

Note: Illegible or incomplete forms will be returned.

MEMBER INFORMATION

Today's Date _____

Urgent

Non-Urgent

Member Name		Date
CareSource PASSE ID	DOB	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
Medication Allergies	Height	Weight kg or lb
Pharmacy	Pharmacy Phone	Pharmacy NPI

DIAGNOSIS INFORMATION

Please provide relevant billable code for requested treatment	Diagnosis Code(s)	Diagnosis Description(s)
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PRESCRIBER INFORMATION

Prescriber First and Last Name	Prescriber NPI	
Prescriber Specialty	Prescriber Address	
Office Fax	Office Phone	Office Contact

MEDICATION REQUESTED

Drug Name & Strength	Dosage Form	Quantity
Directions for Use		
Is the member currently treated on this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, start date:	Is this request for continuation of a previous CareSource PASSE approval? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of approval:	

TRIAL REQUIREMENTS: Refer to CareSourcePASSE.com – Online search tool for drug requirements. Indicate all relevant medication trial information. Complete all sections.

Medication Tried	Strength	Directions for Use	Date of Trial (include MM/DD/YY)	Reason for Discontinuation
1.				
2.				
3.				
4.				

MEDICAL JUSTIFICATION: Indicate all relevant test results, and medical history you would like considered for this review. (Attach Relevant Lab Results and Chart Notes to support answer.)

Provider Signature: _____	Date: _____
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This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at 1-833-230-2100.