Specialty Pharmacy Prior Authorization Form

Pharmacy Benefit Fax: 1-866-930-0019 **Medical Benefit Fax: 1-888-399-0271**

Note: Illegible or incomplete forms will be returned. ☐ Urgent ☐ Non-Urgent

MEMBER INFORMATION	Member Name:			Date:
	CareSource ID:			Sex: Male ❏ Female ❏
	Date of Birth (DOB):	Height:	Weight: ❏ lb. ❏ kg.	Phone:
COORDINATION OF BENEFITS *(as applicable)*	Primary Insurance Name:		Secondary Insurance Name:	
	ID #: Group #:		ID #: Group #:	
MEDICATION INFORMATION	Drug name & strength:		HCPCS Code(s):	
	Directions for Use:		Route of Administration:	
	Dosage Form:		Date(s) of Service Requested: From: _____ To: _____	
DIAGNOSIS FOR TREATMENT	Diagnosis Code(s):		Diagnosis Description(s):	
DOCUMENTATION REQUIREMENT	Prior authorization requests without medical justification, trial information, required test results, etc. will be considered INCOMPLETE. Refer to the corresponding pharmacy policy on **CareSource.com** for drug-specific requirements.			
MEDICATION HISTORY FOR DIAGNOSIS	A. Is the member currently treated on this medication? ❏ YES; Start Date: ❏ NO		B. Is this request for continuation of a previous CareSource approval? ❏ YES ❏ NO If yes, Date of Approval:	
	C. Please document previous trials and treatments provided, including dates and outcomes, below.			
	Drug Name	Dates of Therapy	Reason for Discontinuation	
ADDITIONAL NEEDS (list codes and units)	Home Nursing	Supplies	Other	
			Note: Nursing and supplies will be considered a medical benefit	

SERVICING PROVIDER INFORMATION	Place of Service:	Servicing Provider Name:	Drug claim to be submitted to:
	❏ Prescriber's Office ❏ Out-Patient Facility ❏ Ambulatory Infusion Center ❏ Member's Home	Servicing Provider Address:	❏ Medical Benefit ❏ Pharmacy Benefit
		City: State: Zip Code:	
		Contact Name:	
		Phone #: Fax #:	
		CareSource ID #	
		Tax ID #: NPI #:	

PRESCRIBING PROVIDER INFORMATION	Prescriber Name:		Prescriber Specialty:
	Office Contact:	Phone #:	Fax #:
	Address:		
	City: State: Zip Code:		
	CareSource ID #:	Tax ID #:	NPI #:
	Prescriber Signature:		Date:

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 **1-855-202-1058**.