HAP CareSource™ Specialty Pharmacy Prior Authorization Form

Pharmacy Benefit Fax: 1-866-930-0019
Note: Illegible or incomplete forms will be returned.

Medical Benefit Fax: 1-888-399-0271
☐ Urgent ☐ Standard

Section				
MEMBER INFORMATION	Member Name:			Date:
	Member ID:			
	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, required test results, etc. will be considered INCOMPLETE. Refer to the corresponding pharmacy policy on **HAPCareSource.com** for drug-specific requirements.			
MEDICATION HISTORY FOR DIAGNOSIS	A. Is member currently treated on this medication? ❑ YES; Start Date: ❑ NO		B. Is this request for continuation of a previous HAP CareSource approval? ❑ YES ❑ NO	
	C. Please document previous trials and treatments, 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.	

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

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

Approved Prior Authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits. 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 1-877-514-2442.

MI-EXC-P-3066505