# Pharmacy Prior Authorization Request Form

Pharmacy Fax Number: 1-866-930-0019 ☐ Standard ☐ Urgent

**Note:** Complete all sections – Incomplete or illegible forms will be returned and may delay processing.

## MEMBER INFORMATION

| | |
|---|---|
| Member First and Last Name | Date |
| HAP CareSource™ Member ID | Date of Birth |
| Medication Allergies | Member Height (ft and in) and Weight (lbs) |
| Diagnosis Description | ICD-10 Code |

## PHARMACY INFORMATION

| | |
|---|---|
| Pharmacy | Pharmacy Phone |
| Pharmacy National Provider Identification (NPI) | |

## PRESCRIBER INFORMATION

| | | |
|---|---|---|
| Prescriber Name | | Prescriber Specialty |
| NPI | Office Contact | Office Phone |
| Prescriber Address | | Office Fax |

## MEDICATION REQUESTED

| | |
|---|---|
| Drug Name and Strength | Quantity |
| Directions (Sig) | |
| Check if requesting brand ☐ If yes to brand, explain the medical reason(s) why it is necessary: | |
| Is the member currently treated on this medication?<br>☐ Yes; Date Started (mm/dd/yy):<br>☐ No | |

**MEDICAL JUSTIFICATION**

| Please indicate previous treatments and outcomes below. COMPLETE ALL SECTIONS | | | |
|---|---|---|---|
| Previous Medication | Strength | Dates of Use (*mm/dd/yy to mm/dd/yy*) | Reason(s) for Discontinuation |
| 1) | | | |
| 2) | | | |
| 3) | | | |
| 4) | | | |
| 5) | | | |

Will the member be transitioning from another medication, titrating up/down and/or receive a loading dose as part of this request? If yes, please indicate the treatment plan.

☐ Yes; Treatment Plan: _____

_____

☐ No

Please list any other information you feel is important to this review. Examples include lab or test results, reason for a dosage form not preferred by the Plan, reason for quantity above what the Plan allows, etc. Attach relevant supporting documentation.

By signing this form, the provider attests above information is accurate and documented in the medical record.

| Provider Signature | Date |
|---|---|
| | |