CareSource Rxinnovations

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 ID	Date of Birth (DOB)	Sex Male ❑ Female ❑
Medication Allergies	Height	Weight kg or lb
Pharmacy Name	Pharmacy Phone	Pharmacy NPI Number

DIAGNOSIS INFORMATION

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

PRESCRIBER INFORMATION

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

MEDICATION REQUESTED

Drug Name & Strength	Dosage Form	Quantity
Directions for Use		
Is the member currently treated on this medication? ❑ Yes ❑ No If yes, start date:	Is this request for continuation of a previous CareSource approval? ❑ Yes ❑ No If yes, date of approval:	

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

Medication Trialed	Strength	Qty	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:

Multi-EXC-P-3105409