CareSource Rxi Innovations

# *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) | |
| Indiana Medicaid ID # | Sex<br>Male ❑ Female ❑ | |
| Medication Allergies | Height | Weight<br>kg or lb |
| Pharmacy | Pharmacy Phone # | Pharmacy NPI # |

**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 # |
| 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?<br>❑ Yes ❑ No<br>If yes, start date: | Is this request for continuation of a previous CareSource approval?<br>❑ Yes ❑ No<br>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 | 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.)

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