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

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

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