



# Specialty Pharmacy Prior Authorization Form

Pharmacy Benefit Fax: 1-866-930-0019

Medical Benefit Fax: 1-888-399-0271

Medicaid

Urgent Date of Administration: \_\_\_\_\_

<b>PATIENT INFORMATION</b>	Patient Name:		DOB:		
	Address:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>		
	City/State/Zip:		Phone:		
<b>INSURANCE INFORMATION</b>	Primary Insurance Name:		Secondary Insurance Name:		
	ID #:	Group #:	ID #:	Group #:	
<b>MEDICATION INFORMATION</b>	Drug name & strength:		Dosage form:		
	Dosage (SIG):		Route of administration:		
	Dates of Service: From _____ To _____		J-code:	NDC:	
<b>STATEMENT OF MEDICAL NECESSITY</b>	Primary Diagnosis Code:				
	Rational for request / pertinent clinical information: _____ ATTACH CLINICAL NOTES TO SUPPORT MEDICAL NECESSITY WITH HISTORY AND TREATMENT. Please refer to the corresponding medical policy on <a href="http://CareSource.com">CareSource.com</a>				
<b>MEDICATION HISTORY FOR DIAGNOSIS</b>	A. Is member currently treated on this medication? <input type="checkbox"/> YES; How long? _____ <input type="checkbox"/> NO		B. Is this request for continuation of a previous approval? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	C. Please indicate previous treatment and outcomes below.				
	<b>Drug Name</b>	<b>Dates of Therapy</b>	<b>Reason for Discontinuation</b>		
<b>ADDITIONAL NEEDS</b> (list codes and units)	<b>Home Nursing</b>	<b>Supplies</b>	<b>Other</b>		
	*Note: Nursing and Supplies will be considered a Medical Benefit*				
<b>PERFORMING / SERVICING PROVIDER INFORMATION</b>	<b>Drug Provided By:</b> <input type="checkbox"/> Prescribing Physician <input type="checkbox"/> Accredo Specialty <input type="checkbox"/> Facility <input type="checkbox"/> Facility Pharmacy <input type="checkbox"/> Other		Servicing Provider Name:		Drug Claim to Be Submitted to:  <input type="checkbox"/> Medical Benefit <input type="checkbox"/> Pharmacy Benefit
			Servicing Provider Address:		
			City: _____ State: _____ Zip Code: _____		
			Contact Name:		
			Phone:		
			Fax Number:		
			Tax ID #: _____ NPI#: _____		
<b>PLACE OF SERVICE</b>	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Member's Home <input type="checkbox"/> Ambulatory Infusion Center				
<b>PRESCRIBING PHYSICIAN</b>	Physician Name:		Prescriber Specialty:		
	Office Contact:	Phone:	Fax:		
	Address:				
	City/State/Zip:				
	DEA #:	TAXID #:	NPI #:		
	Physician Signature:			Date:	

Fax completed form with clinical documentation to **1-866-930-0019** for Pharmacy Benefit  
Review OR to **1-888-399-0271** for Medical Benefit Review. Questions? Call: **1-800-488-0134**

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.