



NON-FORMULARY DRUG PRIOR AUTHORIZATION REQUEST FORM

NOTE: Prior Authorization Requests without medical justification or previous medications listed will be considered INCOMPLETE. Illegible or incomplete forms will be returned.

PATIENT INFORMATION

Patient Name		Date
CareSource ID	DOB	SEX

MEDICATION REQUEST

Name of Drug		Strength	Quantity	Days Supply
Refills	Sig.	Diagnosis:		
Treatment Plan & Duration				

REASON FOR REQUEST

Treatment failure with formulary options (please specify):
Patient allergic to formulary alternative (please specify):
Other:

PHYSICIANS INFORMATION

Prescriber Name (Print)		NPI No.
Specialty	Phone	Fax
Mailing Address	City, State	Zip Code

MEDICAL JUSTIFICATION/ INCLUDE OTHER MEDICATIONS TRIED AND RESULTS

1. Previous Medication	Strength	Sig.	Duration (start/end date) & Results
2. Previous Medication	Strength	Sig.	Duration (start/end date) & Results
3. Previous Medication	Strength	Sig.	Duration (start/end date) & Results

CareSource Use Only

Approved / Denied	by: (Medical Director):	Date:
AUTHORIZATION NUMBER:		

230 N. Main Street, Dayton, Ohio 45402
Pharmacy Fax # 866-930-0019

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