



P.O. Box 8738
Dayton, OH 45401-8738

Pharmacy Prior Authorization Request Form

Pharmacy Fax # 866-930-0019

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 Allergies		
Pharmacy	Pharmacy Phone	

PROVIDER INFORMATION

Prescriber Name	NPI #	DEA #
Prescriber Specialty	Prescriber Address	
Office Fax	Phone	Office Contact Name

MEDICATION REQUESTED

Drug Name	Strength	Dose	Directions (Sig)
Duration : Days: _____ Months: _____	Quantity	Refills	Diagnosis
Is the Patient currently treated on this medication? <input type="checkbox"/> Yes; How Long _____ <input type="checkbox"/> No			

Medical Justification: Include Other Relevant Medications Tried and Results

Please indicate previous treatment and outcomes below				
Previous Medication	Strength	Qty	Directions (Sig)	Duration & Reason for Discontinuation
1				
2				
3				
4				
5				

Relevant Medical Rationale for Request/Additional Clinical Information (Including diagnostic studies and lab results)*

Provider Signature	Date

***In order to process this request, please complete all boxes completely and attach relevant notes when appropriate.**

This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately 800-488-0134.