Ohio Medicaid Managed Care
Prior Authorization Request Form

☐ **AMERIGROUP**	☐ **Buckeye Community Health Plan**	☒ **CareSource Ohio**	☐ **Molina Healthcare of Ohio**
FAX: 800-359-5781	**FAX: 866-399-0929**	**FAX: 866-930-0019**	**FAX: 800-961-5160**
Phone: 800-454-3730	Phone: 800-399-0828	Phone: 800-488-0134	Phone: 800-642-4168

Patient Information

Patient Name	DOB		Date
Patient ID #	Sex	Medication Allergies	
Pharmacy	Pharmacy Phone		

Provider Information

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

Medication Request

Drug Name	Strength	Dose	Directions (Sig)
Duration : ☐New ☐3 months ☐ 6 month ☐9 months ☐ 1year	Quantity	Refills	Diagnosis

Is the Patient currently treated on this medication?	☐Yes; How Long_______________	☐ No
Is this a request for continuation of a previous approval?	☐ Yes	☐ No
Has strength, dosage or quantity required per day increased or decreased?	☐ Yes	☐ No
Does the patient have a documented allergy to the medication on the Formulary or PDL?	☐ Yes	☐ No ☐N/A

Medical Justification/Rationale*

Please indicate previous treatment and outcomes below

Drug Name	Strength	Dose	Directions	Duration & Reason for Discontinuation
1				
2				
3				
4				

Patient Previous Medication(s)*

Please indicate previous treatment and outcomes below

Drug Name	Strength	Dose	Directions	Duration & Reason for Discontinuation
1				
2				
3				
4				

Rationale for Request/Additional Clinical Information

Provider Signature		Date
MCP Review: APPROVED / DENIED	By	Date
Authorization Number		

You must submit a copy of chart notes stating that member has tried other medication(s) before.