CareSource
PASSE

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 **Non-Urgent: _____ Urgent: _____**

Patient Name			Date
CareSource ID	DOB	Gender: M/F	
Medication Allergies			
Pharmacy	Pharmacy Phone		
Pharmacy NPI	Patient Height and Weight		

PROVIDER INFORMATION

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

MEDICATION REQUESTED

Drug Name	Strength	Directions (Sig)	
Duration of Therapy Days:______Months: ______	Quantity	HBAIC w/Date (if applicable)	Diagnosis
Is the patient currently treated on this medication? ☐ Yes; date started mm/dd/yy ______/______/______ ☐ No			

MEDICAL JUSTIFICATION: Include other relevant medications tried and results

Please indicate previous treatment and outcomes below

Previous Medication	Strength	Qty	Directions (Sig)	Dates (mm/dd/yy to mm/dd/yy)	Reason for Discontinuation
1					
2					
3					
4					
5					

Relevant Medical Rationale for Request/Additional Clinical Information (Attach Relevant Lab Results and Chart Notes)*

Provider Signature	Date

In order to process this request, please complete all boxes completely.

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 at **1-833-230-2100**.

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