

Specialty Pharmacy Prior Authorization Form

Pharmacy Benefit Fax: 1-866-930-0019

Medical Benefit Fax: 1-888-399-0271

Note: Illegible or incomplete forms will be returned.

☐ Urgent

☐ Standard

MEMBER INFORMATION	Member Name:		Date:	
	Member ID:			
	Date of Birth (DOB):	Height:	Weight: <input type="checkbox"/> lb. <input type="checkbox"/> kg. Phone:	
COORDINATION OF BENEFITS (as applicable)	Primary Insurance Name:		Secondary Insurance Name:	
	ID #:	Group #:	ID #: Group #:	
MEDICATION INFORMATION	Drug Name and Strength:		HCPSC Code(s):	
	Directions for Use:		Route of Administration:	
	Dosage Form:		Date(s) of Service Requested: From: ____ To: ____	
DIAGNOSIS FOR TREATMENT	Diagnosis Code(s):		Diagnosis Description(s):	
DOCUMENTATION REQUIREMENT	Prior authorization requests without medical justification, required test results, etc. will be considered INCOMPLETE. Refer to the corresponding pharmacy policy at CareSourcePASSE.com for drug-specific requirements.			
MEDICATION HISTORY FOR DIAGNOSIS	A. Is member currently treated on this medication? <input type="checkbox"/> YES; Start Date: <input type="checkbox"/> NO		B. Is this request for continuation of a previous approval? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	C. Please document previous trials and treatments, including dates and outcomes below.			
	Drug Name	Dates of Therapy	Reason for Discontinuation	
ADDITIONAL NEEDS (list codes and units)	Home Nursing	Supplies	Other	
			*Note: Nursing and supplies will be considered a medical benefit.	
SERVICING PROVIDER INFORMATION	Place of Service: <input type="checkbox"/> Provider's Office <input type="checkbox"/> Out-Patient Facility <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Member's Home	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 #:	
		CareSource PASSE ID #:		
		Tax ID #:	NPI #:	
PRESCRIBING PROVIDER INFORMATION	Prescriber Name:		Prescriber Specialty:	
	Office Contact:	Phone #:	Fax #:	
	Address:			
	City:	State:	Zip Code:	
	CareSource PASSE ID #:	Tax ID #:	NPI #:	
	Prescriber Signature:		Date:	

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.

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 1-800-230-2100.