Specialty Pharmacy Prior Authorization Form

Medical Benefit Fax: 888-399-0271 ***Pharmacy Benefit Fax: 866-930-0019*** ☐ Urgent Date of Administration:____________

<table>
<tr><td rowspan="3">PATIENT INFORMATION</td><td colspan="3">Patient Name:</td><td>DOB:</td></tr>
<tr><td colspan="3">Address:</td><td>Sex: M ❑ F ❑</td></tr>
<tr><td colspan="2">City/State/Zip:</td><td colspan="2">Phone:</td></tr>
<tr><td rowspan="2">INSURANCE INFORMATION</td><td colspan="2">Primary Insurance Name:</td><td colspan="2">Secondary Insurance Name:</td></tr>
<tr><td colspan="2">ID #: Group #:</td><td colspan="2">ID #: Group #:</td></tr>
<tr><td rowspan="3">MEDICATION INFORMATION</td><td colspan="2">Drug name & strength:</td><td colspan="2">Dosage form:</td></tr>
<tr><td colspan="2">Dosage (SIG):</td><td colspan="2">Route of administration:</td></tr>
<tr><td colspan="2">Dates of Service: From___________ To____________</td><td>J-code:</td><td>NDC:</td></tr>
<tr><td rowspan="2">STATEMENT OF MEDICAL NECESSITY</td><td colspan="4">Primary Diagnosis Code:</td></tr>
<tr><td colspan="4">Rational for request / pertinent clinical information: ____
ATTACH CLINICAL NOTES TO SUPPORT MEDICAL NECESSITY WITH HISTORY AND TREATMENT.
Please refer to the corresponding medical policy on CareSourcePASSE.com</td></tr>
<tr><td rowspan="6">MEDICATION HISTORY FOR DIAGNOSIS</td><td colspan="2">A. Is member currently treated on this medication?
❑ YES; How long?________________ ❑ NO</td><td colspan="2">B. Is this request for continuation of a previous approval?
❑ YES ❑ NO</td></tr>
<tr><td colspan="4">C. Please indicate previous treatment and outcomes below.</td></tr>
<tr><td>Drug Name</td><td>Dates of Therapy</td><td colspan="2">Reason for Discontinuation</td></tr>
<tr><td></td><td></td><td colspan="2"></td></tr>
<tr><td></td><td></td><td colspan="2"></td></tr>
<tr><td></td><td></td><td colspan="2"></td></tr>
<tr><td rowspan="3">ADDITIONAL NEEDS
(list codes and units)</td><td>Home Nursing</td><td>Supplies</td><td colspan="2">Other</td></tr>
<tr><td></td><td></td><td colspan="2"></td></tr>
<tr><td></td><td></td><td colspan="2">*Note: Nursing and supplies will be considered a medical benefit*</td></tr>
<tr><td>PERFORMING / SERVICING PROVIDER INFORMATION</td><td>Drug Provided By:
❑ Prescribing Physician
❑ Accredo Specialty
❑ Facility
❑ Facility Pharmacy
❑ Other</td><td colspan="2">Servicing Provider Name:
Servicing Provider Address:
City: State: Zip Code:
Contact Name:
Phone:
Fax Number:
Tax ID #: NPI #:</td><td>Drug Claim to be submitted to:
❑ Medical Benefit
❑ Pharmacy Benefit</td></tr>
<tr><td>PLACE OF SERVICE</td><td colspan="4">❑ Physician's Office ❑ Outpatient Hospital ❑ Member's Home ❑ Ambulatory Infusion Center</td></tr>
<tr><td rowspan="6">PRESCRIBING PHYSICIAN</td><td colspan="2">Physician Name:</td><td colspan="2">Prescriber Specialty:</td></tr>
<tr><td>Office Contact:</td><td colspan="2">Phone:</td><td>Fax:</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td colspan="4">City/State/Zip:</td></tr>
<tr><td>DEA #:</td><td colspan="2">Tax ID #:</td><td>NPI #:</td></tr>
<tr><td colspan="3">Physician Signature:</td><td>Date:</td></tr>
</table>

Fax completed form with clinical documentation to **866-930-0019** for pharmacy benefit review OR to **888-399-0271** for medical benefit review. Questions? Call **1-833-230-2100.**

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.