



Specialty Pharmacy Prior Authorization Form

Medical Benefit Fax: 1-888-399-0271

Note: Illegible or incomplete forms will be returned.

☐ Urgent

☐ Standard

BENEFICIARY INFORMATION	Beneficiary Name:		Date:	
	Beneficiary 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 & Strength:		HCPCS 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 CareSourceMilitary.com for drug-specific requirements.			
MEDICATION HISTORY FOR DIAGNOSIS	A. Is beneficiary currently treated on this medication? <input type="checkbox"/> YES; Start Date: <input type="checkbox"/> NO		B. Is this request for continuation of a previous CSMV 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"/> Prescriber's Office <input type="checkbox"/> Out-Patient Facility <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Beneficiary's Home	Servicing Provider Name:		Drug claim to be submitted to: <input type="checkbox"/> Medical Benefit
		Servicing Provider Address:		
		City:	State: Zip Code:	
		Contact Name:		
		Phone #:	Fax #:	
		CareSource ID #:		
		Tax ID #: NPI #:		
PRESCRIBING PROVIDER INFORMATION	Prescriber Name:		Prescriber Specialty:	
	Office Contact:	Phone #:	Fax #:	
	Address:			
	City:	State:	Zip Code:	
	CareSource ID #:	Tax ID #:	NPI #:	
	Prescriber Signature:		Date:	

Approved Prior Authorizations are contingent upon the eligibility of beneficiary 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.