



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: _____		
	Beneficiary ID: _____		
	Date of Birth (DOB): _____	Height: _____	Weight: _____ lb. _____ kg. Phone: _____
COORDINATION OF BENEFITS (as applicable)	Primary Insurance Name: _____		Secondary Insurance Name: _____
	ID #: _____ Group #: _____		ID #: _____ Group #: _____
	Drug Name & Strength: _____		HCPCS Code(s): _____
MEDICATION INFORMATION	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: _____	
		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 #: _____
	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.