CareSource

Prior Authorization Request Form

Please Fax to: (866) 930-0019 Date of Request: _____

Provider's Name:			
Provider's DEA/NPI:		Specialty:	
Phone #		Fax #	
Provider's Address:			

Member's Name:		DOB:	
CSMG ID:		Gender:	
Patient's Diagnosis:			

Medication Needed:		Strength:		Quantity:	
Directions:		Duration:			
Refills		How many?			

Has this patient tried and failed other medications for this condition? (List drug, duration etc.)

Medication	Strength	Sig.	Duration

Clinical rationale for selected drug usage: _____

Is the patient currently taking this drug? _____
If so, how long? _____

What medications do you want to discontinue or stop? _____

Patient allergic to formulary alternative? _____
If yes, supply details: _____

***** All fields must be complete and legible for Prior Authorization Review *****

One Dayton Center, One S. Main Street, Dayton Ohio 45402
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