

# Pharmacy Prior Authorization Request Form

## Pharmacy Fax # 866-930-0019

Note: Prior Authorization Requests without medical justification or previous medications listed will be considered INCOMPLETE; illegible or incomplete forms will be returned.

### PATIENT INFORMATION

Non-Urgent: \_\_\_\_\_ Urgent: \_\_\_\_\_

Patient Name		Date
CareSource ID	DOB	Gender: M/F
Medication Allergies		
Pharmacy	Pharmacy Phone	
Pharmacy NPI:	Patient Height and Weight:	

### PROVIDER INFORMATION

Prescriber Name	NPI #	DEA #
Prescriber Specialty	Prescriber Address	
Office Fax	Phone	Office Contact Name

### MEDICATION REQUESTED

Drug Name	Strength	Directions (Sig)	
Duration of Therapy: Days: _____ Months: _____	Quantity	HBA1C w/Date (if applicable)	Diagnosis
Is the Patient currently treated on this medication? <input type="checkbox"/> Yes; Date Started mm/dd/yy _____ / _____ / _____ <input type="checkbox"/> No			

### MEDICAL JUSTIFICATION: Include Other relevant medications tried and results

Please indicate previous treatment and outcomes below					
Previous Medication	Strength	Qty	Directions (Sig)	Dates (mm/dd/yy to mm/dd/yy)	Reason for Discontinuation
1					
2					
3					
4					
5					

### Relevant Medical Rationale for Request/Additional Clinical Information (Attach Relevant Lab Results and Chart Notes)\*

Provider Signature	Date
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**\*In order to process this request, please complete all boxes completely.**

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 **1-855-202-1058**.