



P.O. Box 8738  
Dayton, OH 45401-8738

## 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

Patient Name		Date
CareSource ID	DOB	Gender: M/F
Medication Allergies		
Pharmacy	Pharmacy Phone	

### 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	HBAIC 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

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

**CareSource will review and issue a decision within 24 hours of the original receipt of a pharmacy prior authorization request**

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 1-855-202-1058

GA-P-0181