Specialty Pharmacy Prior Authorization Form

Pharmacy Benefit Fax: 1-866-930-0019
Note: Illegible or incomplete forms will be returned.

Medical Benefit Fax: 1-888-399-0271
☐ Urgent ☐ Non-Urgent

MEMBER INFORMATION	Member Name:			Date:
	CareSource ID:		Indiana Medicaid 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 #:	
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, trial information, required test results, etc. will be considered INCOMPLETE. Refer to the corresponding pharmacy policy on **CareSource.com** for drug-specific requirements.			
MEDICATION HISTORY FOR DIAGNOSIS	A. Is member currently treated on this medication? ❑ YES; Start Date: ❑ NO		B. Is this request for continuation of a previous CareSource approval? ❑ YES ❑ 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: ❑ Prescriber's Office ❑ Out-Patient Facility ❑ Ambulatory Infusion Center ❑ Member's Home	Servicing Provider Name: Servicing Provider Address: City: State: Zip Code: Contact Name: Phone #: Fax #: CareSource ID #: Tax ID #: NPI #:		Drug claim to be submitted to: ❑ Medical Benefit ❑ Pharmacy Benefit
PRESCRIBING PROVIDER INFORMATION	Prescriber Name:		Prescriber Specialty:	
	Office Contact:	Phone #:		Fax #:
	Address:			
	City:	State:		Zip Code:
	CareSource ID #:	Tax ID #:		NPI #:
	Prescriber Signature:			Date: