

Specialty Pharmacy Prior Authorization Form

Pharmacy Benefit Fax: 1-866-930-0019 Medical Benefit Fax: 1-888-399-0271

PATIENT INFORMATION Address: City/State/Zip: Phone: Phone	Medicaid	☐ Urgent Date of Administration:						
Address: Sex: M F	PATIENT	Patient Name:					DOB:	
INSURANCE INFORMATION MEDICATION INFORMATION MEDICATION INFORMATION MEDICATION INFORMATION Dosage (SIG): Dates of Service: From		Address:					Sex: M □ F	FO
MEDICATION ID #: Group #: ID		City/State/Zip: Pho				ne:		
MEDICATION INFORMATION Dosage (SIG): Dates of Service: FromTo	INFORMATION	Primary Insurance Name: Secondary Insurance Name:					ie:	
Dosage (SiG): Dates of Service: From		ID #: Group #:			ID#:	Group#:		
Dates of Service: FromTo		Drug name & strength:			Dosage form:			
Primary Diagnosis Code: Rational for request / pertinent clinical information: ATTACH CLINICAL NOTES TO SUPPORT MEDICAL NECESSITY WITH HISTORY AND TREATMENT. Please refer to the corresponding medical policy on CaroSource.com	INFORMATION	Dosage (SIG):			Route of administration:			
Rational for request / pertinent clinical information:		Dates of Service: FromTo			J-code:	-code: NDC:		
NECESSITY ATTACL CLINICAL NOTES TO SUPPORT MEDICAL NECESSITY WITH HISTORY AND TREATMENT. Please refer to the corresponding medical policy on CareSource.com	STATEMENT							
HISTORY FOR DIAGNOSIS YES; How long?		ATTACH CLINICAL NOTES TO SUPPORT MEDICAL NECESSITY WITH HISTORY AND TREATMENT.						
DIAGNOSIS C. Please indicate previous treatment and outcomes below. Drug Name Dates of Therapy Reason for Discontinuation Reason for Discontinuation Passon for Discontinuation Pass	MEDICATION	,						
Drug Name Dates of Therapy Reason for Discontinuation Reason for D			□ YES □ NO					
ADDITIONAL NEEDS (Ilist codes and units) PERFORMING / SERVICING PROVIDER INFORMATION PACE OF SERVICE PRESCRIBING PHYSICIAN PRESCRIBING PHYSICIAN PRESCRIBING Physician 'S Office Office Office Contact: Physician Name: Prescriber Specialty: Phone: Fax: Address: City/State/Zip: DEA #: TAXID #: NPI#: ADDITIONAL NEEDS Supplies Other And Note: Nursing and Supplies will be considered a Medical Benefit	DIAGNOSIS							
NEEDS (list codes and units) PERFORMING / SERVICING Prescribing Physician Accredo Specialty Facility Facility Phone: Fax Number: Tax ID#: Phone: Fax:		DrugName	Dates of Therap	ру	Reason for Discont	tinuation	1	
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SERVICING PROVIDER INFORMATION Prescribing Physician Servicing Provider Address: Medical Benefit Pharmacy Servicing Provider Address: Phone: Fax Number: Phone: Fax Number: Phone: Fax Number: Phone: Physician's Office Outpatient Hospital Member's Home Ambulatory Infusion Center PRESCRIBING Physician Name: Prescriber Specialty: Phone: Fax: Address: City/State/Zip: DEA #: TAXID #: NPI#: N	NEEDS	Home Nursing	Supplies			unnline wi	ill be considered a	Modical Ronofit*
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Facility Pharmacy Other	NEEDS (list codes and units) PERFORMING /	Drug Provided By:		der Name:		upplies wi	ill be considered a	Drug Claim to
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Fax completed form with clinical documentation to **1-866-930-0019** for Pharmacy Benefit Review OR to **1-888-399-0271** for Medical Benefit Review. Questions? Call: **1-800-488-0134**

Approved Prior Authorizations are contingent upon the eligibility of member 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.

IN-MED-P-66927-V.2 Issue Date: 7/6/2021 OMPP Approved: 6/1/2021