INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
EARLY REFILL PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: 866-930-0019

CareSource RxInnovations

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

*****All sections must be completed or the request will be returned.*****

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service requested: _____ Start Date: _____

Please select reason for request below:

Retail Pharmacy:

- ☐ Previous claim has wrong days supply and cannot be reversed/resubmitted
- ☐ Change in dosage
- ☐ School/work supply for non-transportable items
- ☐ Released from hospital, Long Term Care (LTC) facility, or group home
- ☐ Vacation/absence from Indiana residence to place outside of Indiana (1 approved request per medication per 365 days)
- ☐ Non-controlled medication lost, spilled, or damaged (1 approved request per medication per 365 days)
- ☐ Non-controlled medication stolen or destroyed by fire (documentation from law enforcement or insurance must be attached), or destroyed by a natural disaster

Controlled medication: (Requires prescriber's signature, LTC facility requests will be denied)

- ☐ Medication has been lost or spilled (1 approved request per medication per 365 days)
- ☐ Medication has been stolen or destroyed by fire (documentation from law enforcement or insurance must be attached), or destroyed by a natural disaster

LTC Pharmacy: (Controlled and Non-controlled)

- ☐ Previous claim has wrong days supply and cannot be reversed/resubmitted
- ☐ Change in dosage
- ☐ New admit or re-admit
- ☐ Patient is going on leave of absence
- ☐ Patient has a PRN order and a routine order with different prescription numbers

Medication	Strength	Dosage Form

If necessary, add a brief summary that would help document the need for an early refill of the medications listed above.

I attest the provided information above is accurate:

Physician Signature: _____ **Date:** _____