CareSource Rxinnovations

# INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
# HIGH DOLLAR COMPOUNDED PRESCRIPTION CLAIM PRIOR AUTHORIZATION REQUEST FORM

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

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: _____<br>Start Date:_____ |

Requested Compound Ingredient List:
_____
_____

| Dosage | Form | Directions for Use | Quantity |
|---|---|---|---|
| | | | |

**PA requirements:**

1. Compound requested meets all federal and state legal requirements ☐ Yes ☐ No
2. Pharmacist or prescriber has verified the validity of the claim; including quantity and components
   ☐ Yes ☐ No
3. Faxed documentation for clinical rationale or medical justification (medical chart records indicating previous trial of commercially available therapeutic alternatives, alternatives are unsuitable for use, no reasonable therapeutic alternatives, supporting literature, etc.) for use is attached
   ☐ Yes ☐ No

If no, please explain:
_____
_____
_____

I attest that the provided information above is accurate:

**Physician Signature: _____ Date: _____**