CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
TOPICAL AGENT 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: _____ Start Date: _____

Requested Medication	Strength	Quantity	Directions for Use	ICD-10 Diagnosis

PA Requirements

1. What is the prescriber's specialty? _____

2. Have any other providers been consulted in the prescribing of the requested agent? ☐ Yes ☐ No
   If yes, please provide the other provider's specialty: _____

3. Has the member tried and failed any other medication(s) for the requested diagnosis? ☐ Yes ☐ No
   If yes, please provide drug/dose/date(s) of use: _____

Drug Name and Dose	Quantity	Dates of Use	Reason(s) Stopped

4. Provide medical justification for use at requested dose and duration:

_____

_____

_____

Additional Drug-Specific Questions: (Not required if not applicable)

Topical Nonsteroidal anti-inflammatory drugs (NSAIDs):

1. Are oral medications unsuitable for member use? □ Yes □ No

   If yes, why? _____

   Documentation (e.g., medical chart record) is required to be attached.

I attest that the information provided is accurate:

Physician Signature: _____ **Date: _____**