INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
TOPICAL AGENT PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization (PA) 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: _____

Requested Medication	Strength	Quantity	Directions for Use	ICD-10 Diagnosis

PA Requirements

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

2. 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

3. 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 the information provided above is accurate:

Physician Signature: _____ **Date: _____**

CONFIDENTIAL INFORMATION
This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you received this in error, please notify us by telephone immediately at **1-844-607-2831**.