P.O. Box 8738
Dayton, OH 45401-8738

Pharmacy Prior Authorization Request Form

Pharmacy Fax # 866-930-0019

Note: Prior Authorization Requests without medical justification or previous medications listed will be considered INCOMPLETE; illegible or incomplete forms will be returned.

PATIENT INFORMATION

Non-Urgent: _____ Urgent: _____

Patient Name		Date
CareSource ID	DOB	Gender: M/F
Medication Allergies		
Pharmacy	Pharmacy Phone	
Pharmacy NPI:	Patient Height and Weight:	

PROVIDER INFORMATION

Prescriber Name	NPI #	DEA #
Prescriber Specialty	Prescriber Address	
Office Fax	Phone	Office Contact Name

MEDICATION REQUESTED

Drug Name	Strength	Directions (Sig)	
Duration of Therapy: Days:_____Months: _____	Quantity	HBAIC w/Date (if applicable)	Diagnosis
Is the Patient currently treated on this medication? ☐ Yes; Date Started mm/dd/yy_____/_____/_____ ☐ No			

MEDICAL JUSTIFICATION: Include Other relevant medications tried and results

Please indicate previous treatment and outcomes below					
Previous Medication	Strength	Qty	Directions (Sig)	Dates (mm/dd/yy to mm/dd/yy)	Reason for Discontinuation
1					
2					
3					
4					
5					

Relevant Medical Rationale for Request/Additional Clinical Information (Attach Relevant Lab Results and Chart Notes)*

Provider Signature	Date

In order to process this request, please complete all boxes completely.