



## Specialty Pharmacy Prior Authorization Form

Pharmacy Benefit fax: 866-930-0019

Medical Benefit Fax: 888-399-0271

Marketplace

Urgent  Date of Administration \_\_\_\_\_

<b>PATIENT INFORMATION</b>	Patient Name:		DOB:	
	Address:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>	
	City/State/Zip:		Phone:	
<b>INSURANCE INFORMATION</b>	Primary Insurance Name:		Secondary Insurance Name:	
	ID #:	Group #:	ID #:	Group #:
<b>MEDICATION INFORMATION</b>	Drug name & strength:		Dosage form:	
	Dosage (SIG):		Route of administration:	
	Dates of Service: From _____ To _____		J-code:	NDC:
<b>STATEMENT OF MEDICAL NECESSITY</b>	Primary Diagnosis Code:			
	Rational for request / pertinent clinical information: _____ <b>ATTACH CLINICAL NOTES TO SUPPORT MEDICAL NECESSITY WITH HISTORY AND TREATMENT.</b> Please refer to the corresponding medical policy on <a href="http://www.caresource.com">www.caresource.com</a>			
<b>MEDICATION HISTORY FOR DIAGNOSIS</b>	A. Is member currently treated on this medication? <input type="checkbox"/> YES; How long? _____ <input type="checkbox"/> NO		B. Is this request for continuation of a previous approval? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	C. Please indicate previous treatment and outcomes below.			
	Drug Name	Dates of Therapy	Reason for Discontinuation	
<b>ADDITIONAL NEEDS</b> (list codes and units)	Home Nursing	Supplies	Other	
			*Note: Nursing and Supplies will be entered in Medical Benefit*	
<b>DRUG CLAIM TO BE SUBMITTED BY</b>	<input type="checkbox"/> Prescribing Physician		Dispensing Pharmacy:	
	<input type="checkbox"/> Accredo Specialty		Contact Name:	
	<input type="checkbox"/> Facility		Phone:	
	<input type="checkbox"/> Other		Fax Number:	
			Tax ID #:	NPI#:
<b>DRUG CLAIM TO BE SUBMITTED TO:</b>	<input type="checkbox"/> Medical Benefit			
	<input type="checkbox"/> Pharmacy Benefit			
<b>PLACE OF SERVICE</b>	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Member's Home <input type="checkbox"/> Ambulatory Infusion Center			
<b>PRESCRIBING PHYSICIAN</b>	Physician Name:		Prescriber Specialty:	
	Office Contact:	Phone:	Fax:	
	Facility:			
	Address:			
	City/State/Zip:			
	License #:	DEA#:	NPI#:	
	Physician Signature:			Date:

**Fax completed form with clinical documentation to 866-930-0019 for Pharmacy Benefit Review  
OR to 888-399-0271 for Medical Benefit Review. Questions? Call: 1-800-488-0134**

Approved Prior Authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits.  
Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits.