HAP CareSource™

PHARMACY BENEFIT MEDICATION PRIOR AUTHORIZATION FORM

HAP CareSource Pharmacy Department
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 Medicaid ID ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's MI License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact (Name & title of person completing form)
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service : _____ Start Date: _____

Patient's Known Medication Allergies:

NOTE: Please access the HAP CareSource Medicaid Pharmacy Page at HAPCareSource.com for a list of preferred medications and drug policies.

Requested Medication (one medication request per form)

Drug Name:	Strength:
Dosage Form:	Route:
Directions for use:	Quantity:
Length of therapy:	Therapy start date: ☐☐ / ☐☐ / ☐☐☐☐

Diagnosis (diagnosis for the requested treatment) *Include ICD-10 code and description

Primary ICD-10 code and description(s) for treatment:_____ _____

Secondary ICD-10 code/description:_____ _____

Tertiary ICD-10 code/description:_____ _____

Patient weight:_____ (kg) _____ (lb) Patient height:_____

Medication History

A. Is the member currently on this medication? ____ Yes, go to B ___ No, go to E

B. Is this a request for a continuation of a previous CareSource approval? ____Yes ___ No

C. Is the strength, dose, or directions for use changing? ____Yes ____ No

D. Describe the benefits gained from this medication.
NOTE: Also, attach any office visit records, lab results, imaging results you want considered with this request.

_____
_____
_____

E. Have other medications been tried for this diagnosis prior to this request? ___ Yes, go to F ___ No, go to G

F. Use the table below to list all medications previously used to treat this condition. If more room is needed, use Section I. Please list all medications that have been tried, including OTC if applicable.

Drug Name	Strength	Dose	Start and Stop Dates	Reason Stopped
1.				
2.				
3.				
4.				
5.				

G. Is there a medical reason preferred medication(s) cannot be tried by the member? ____ Yes ____No

H. List the medical reason(s) preferred medication(s) cannot be tried by the member. (Examples allergies/contraindications)

_____
_____
_____

I. List additional comments/attach any lab, imaging and other test results, or chart notes you want considered.

_____
_____
_____

I attest the provided information above is accurate:

Physician Signature: _____ **Date:** _____

Approved Prior Authorizations are contingent upon the eligibility of member at the time of service, timely filing, and claim limitations. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits. Incomplete or illegible forms will delay processing. For questions please call HAP CareSource Provider Services at: <1-833-230-2102>.