CareSource Rxi Innovations

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

# *Pharmacy Prior Authorization Request Form*

## Pharmacy Fax Number: 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 North Carolina Co. 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) | Billable Diagnosis and ICD-10 code: |
| 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)***
For medication reauthorization, please submit documentation such as radiology summaries, labs and chart notes that show benefit for continuation of therapy.

| | |
|---|---|
| Provider Signature | Date |

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