CareSource®
Health Care with Heart

Drugs Under Medical Benefit
Prior Authorization Form

Medical Benefit Fax: 1-888-299-0271

Note: Illegible or incomplete forms will be returned   Urgent   Non-Urgent

Member Information	Member Name:			Date:	
	CareSource ID:			Sex: Male Female	
	Date of Birth:	Height:	Weight:	Phone:	
Coordination of Benefits (as applicable)	Primary Insurance Name:		Secondary Insurance Name:		
	ID:	Group ID:	ID:		Group ID:
Medication Information	Drug Name and Strength:		HCPCS Code(s):		
	Directions for Use:		Route of Administration:		
	Dosage Form:		Date(s) of Service Requested: From: To:		
Diagnosis for Treatment	Diagnosis Code(s):				
	Diagnosis Description(s):				
Documentation Requirement	Prior authorization requests without medical justification, trial information, required test results, etc. will be considered INCOMPLETE. Refer to the corresponding pharmacy policy on CareSource.com for drug-specific requirements.				

Medication History for Diagnosis	A. Is member currently treated on this medication? 　　　YES　　　　　NO If yes, Date of Start:	B. Is this request for continuation of previous CareSource approval? 　　　YES　　　　　NO If yes, Date of Approval:

C. Please document previous trials and treatments provided, including dates and outcomes below.		
Drug Name	Dates of Therapy	Reason(s) for Discontinuation

Additional Needs (list codes and units)	Home Nursing	Supplies	Other
			*Note: Nursing and supplies will be considered a medical benefit.

| **Servicing Provider Information** | Place of Service:

　　Prescriber's Office

　　Out-Patient Facility

　　Ambulatory Infusion Center

　　Member's Home | Servicing Provider Name:

Servicing Provider Address:

City:　　　　　State:　　　ZIP Code:

Servicing Provider Contact Name:

Phone:　　　　　　　　Fax:

CareSource ID:

Tax ID:　　　　　　　　NPI: |

Prescribing Provider Information	Prescribing Provider Name: Prescribing Provider Specialty: Prescribing Provider Contact Name:　　　　　　　Phone: Fax:　　　　　Prescribing Provider Address: CareSource ID:　　　　　Tax ID:　　　　　NPI:
	Prescribing Provider Signature:　　　　　　　Date: