



**Drugs Under Medical Benefit
Prior Authorization Form**

Medical Benefit Fax: 1-888-399-0271

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.				

This facsimile and any attached document(s) are confidential and intended for use of the individual or entity to which it is addressed. If you received this in error, please notify us by telephone immediately at **1-800-488-0134**.

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:	