CareSource

# Specialty Pharmacy Prior Authorization Form

***Pharmacy Benefit Fax: 1-866-930-0019*** ***Medical Benefit Fax: 1-888-399-0271***

☐ Non-Urgent ☐ Urgent Date of Administration: _____

| | | | |
|---|---|---|---|
| **PATIENT INFORMATION** | Patient Name: | | DOB: |
| | Address: | | Sex: M ❑ F ❑ |
| | City/State/Zip: | Phone: | |
| **INSURANCE INFORMATION** | Primary Insurance Name: | Secondary Insurance Name: | |
| | ID #: Group #: | ID #: Group #: | |
| **MEDICATION INFORMATION** | Drug name & strength: | Dosage form: | |
| | Dosage (SIG): | Route of administration: | |
| | Dates of Service: From_____ To_____ | HCPCS/J-code: | NDC: |
| **STATEMENT OF MEDICAL NECESSITY** | Billable Primary Diagnosis and ICD-10 Code: | | |
| | Rational for request / pertinent clinical information: _____ ATTACH CLINICAL NOTES TO SUPPORT MEDICAL NECESSITY WITH HISTORY AND TREATMENT. Please refer to the corresponding medical policy on **CareSource.com** | | |
| **MEDICATION HISTORY FOR DIAGNOSIS** | A. Is the member currently treated on this medication? ❑ YES; How long?_____ ❑ NO | B. Is this request for continuation of a previous approval? ❑ YES ❑ NO | |
| | C. Please indicate previous treatment and outcomes below. | | |
| | Drug Name, Strength and Dosing | Dates of Therapy | Reason for Discontinuation |
| | | | |
| | | | |
| | | | |
| **ADDITIONAL NEEDS** (list codes and units) | Home Nursing | Supplies | Other |
| | | | |
| | | | *Note: Nursing and Supplies will be considered a Medical Benefit* |

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| **PERFORMING / SERVICING PROVIDER INFORMATION** | **Drug Provided By:** ❑ Prescribing Physician ❑ Accredo Specialty ❑ Facility ❑ Facility Pharmacy ❑ Other | Servicing Provider Name: | Drug Claim to Be Submitted to: ❑ Medical Benefit ❑ Pharmacy Benefit |
| | | Servicing Provider Address: | |
| | | City: State: Zip Code: | |
| | | Contact Name: | |
| | | Phone: | |
| | | Fax Number: | |
| | | Tax ID #: NPI #: | |

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|---|---|---|---|
| **PLACE OF SERVICE** | ❑ Physician's Office ❑ Outpatient Hospital ❑ Member's Home ❑ Ambulatory Infusion Center | | |
| **PRESCRIBING PHYSICIAN** | Physician Name: | Prescriber Specialty: | |
| | Office Contact: | Phone: | Fax: |
| | Address: | | |
| | City/State/Zip: | | |
| | DEA #: | Tax ID #: | NPI #: |
| | Physician Signature: | | Date: |

Fax completed form with clinical documentation to **1-866-930-0019** for Pharmacy Benefit Review OR to **1-888-399-0271** for Medical Benefit Review. Questions? Call: **1-833-230-2101**

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.