



Provider Administered Drug Prior Authorization Form

Please submit this completed form online
OR
FAX to: 888-399-0271 for Medical Benefit

OH Medicaid

Urgent Date of Administration: _____

PATIENT INFORMATION	Patient Name:		Date of Birth:		
	Address:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>		
	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 _____		J-code:	NDC:	
STATEMENT OF MEDICAL NECESSITY	Primary Diagnosis 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 member currently treated on this medication? <input type="checkbox"/> YES; How long? _____ <input type="checkbox"/> NO		B. Is this request for continuation of a previous approval? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	C. Please indicate previous treatment and outcomes below.				
	Drug Name	Dates of Therapy	Reason for Discontinuation		
ADDITIONAL NEEDS <small>(list codes and units)</small>	Home Nursing	Supplies	Other		
	Note: Nursing and Supplies will be considered a Medical Benefit				
PERFORMING / SERVICING PROVIDER INFORMATION (Provider type 70 must submit request through Pharmacy Benefit)	Drug Provided By: <input type="checkbox"/> Prescribing Physician <input type="checkbox"/> Facility <input type="checkbox"/> Other		Servicing Provider Name:		Drug Claim to Be Submitted to: <input type="checkbox"/> Medical Benefit
			Servicing Provider Address:		
			City: _____ State: _____ Zip Code: _____		
			Contact Name:		
			Phone:		
			Fax Number:		
			Tax ID #: _____ NPI #: _____		
PLACE OF SERVICE	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Member's Home <input type="checkbox"/> Ambulatory Infusion Center				
PRESCRIBING PHYSICIAN	Physician Name:		Prescriber Specialty:		
	Office Contact:		Phone:	Fax:	
	Address:				
	City/State/Zip:				
	DEA #:		TAXID #:	NPI #:	
	Physician Signature:			Date:	

Provider Administered Outpatient Drugs Review. Questions? Call: **1-800-488-0134**

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.