Pharmacy Benefit Prior Authorization Request Form

Pharmacy Fax: 866-930-0019

Note: Illegible or incomplete forms will be returned.

MEMBER INFORMATION Today's Date _____ o Urgent o Non-Urgent

Member Name		Date
CareSource ID	Date of Birth (DOB)	Sex Male o Female o
Medication Allergies	Height	Weight kg or lb
Pharmacy Name	Pharmacy Phone	Pharmacy NPI Number

DIAGNOSIS INFORMATION

Please provide relevant billable code for requested treatment	Diagnosis Code(s)	Diagnosis Description(s)

PRESCRIBER INFORMATION

Prescriber First and Last Name	Prescriber NPI Number
Prescriber Specialty	Prescriber Address

Office

Multi-EXC-P-3105409