

# Pharmacy Benefit Prior Authorization Request Form

Pharmacy Fax: 866-930-0019

Note: Illegible or incomplete forms will be returned.

MEMBER INFORMATION		Today's Date _____	<input type="radio"/> Urgent	<input type="radio"/> Non-Urgent
Member Name			Date	
CareSource ID	Date of Birth (DOB)	Sex Male <input type="radio"/> Female <input type="radio"/>		
Medication Allergies	Height	Weight kg or lb		
Pharmacy Name	Pharmacy Phone	Pharmacy NPI Number		
<b>DIAGNOSIS INFORMATION</b>				
Please provide relevant billable code for requested treatment	Diagnosis Code(s)	Diagnosis Description(s)		
<b>PRESCRIBER INFORMATION</b>				
Prescriber First and Last Name			Prescriber NPI Number	
Prescriber Specialty	Prescriber Address			
Office				

Multi-EXC-P-3105409

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