



SPECIALTY MEDICATION PRIOR AUTHORIZATION FORM

Complete this form and send information to
Buckeye Community Health Plan, Pharmacy Department
fax at **1-866-704-3066**
For questions, please call 1-866-246-4356

Caremark Ship to: Patient Office Other: _____ **OR** Office Stock Use

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	NPI#: _____
City, St Zip: _____	Group or Hospital: _____
Home Phone: _____	Address: _____
Alternate Phone: _____	City, St Zip: _____
Date of Birth: _____	Phone: _____
Gender: _____	Fax: _____
	Contact Name: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____ Phone#: _____
 Secondary Insurance: _____ ID#: _____ Phone#: _____

STATEMENT OF MEDICAL NECESSITY

<p>Diagnosis: Please include ICD9 and description</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Date of Diagnosis: _____</p> <p>Please include any diagnostic clinicals such as labs, radiology, exams, etc.</p>	<p>Additional Clinical Information:</p> <ul style="list-style-type: none"> • Weight: _____ kg/lbs • Height: _____ in/cm • Lab Data (Please include copies of reports): _____ • Other Medications: _____ • Additional Comments: _____
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Is member currently treated with this medication(s)? No ___ Yes ___ How long: _____
 Is this request a continuation of a previous approval by Buckeye? No ___ Yes ___
 Has the strength, dosage or quantity required per day: Increased ___ Decreased ___ Same ___

Medication(s) Requested

Therapy Start Date: _____

Rx

Medication Name	Strength/Dose	Directions	Quantity	Refills

Prescriber's Signature

Date