**MEDICAID**

**MEDICATION PRIOR AUTHORIZATION REQUEST FORM**
**Buckeye Health Plan, Ohio**
**(Do Not Use This Form for Biopharmaceutical Products)**

https://www.covermymeds.com/main/prior-authorization-forms/

buckeye health plan

## FAX this completed form to 1-844-205-3383

**OR Mail requests to: Pharmacy Services PA Dept / 5 River Park Place East, Suite 210 / Fresno, CA 93720**
**Call 866.399.0928 to request a 72-hour supply of medication.**

| I. Provider Information | | II. Member Information |
|---|---|---|
| Prescriber name (print): | | Member name: |
| Prescriber Specialty: | | Identification number: |
| Fax: | Phone: | Date of Birth: |
| Office Contact Name: | | Medication allergies: |

## III. Drug Information *(One drug request per form)*

| Drug name and strength: | Dosage form: | Dosage interval (sig): | Qty per Day: |
|---|---|---|---|
| | | | |

Diagnosis relevant to ***this*** request:

Expected length of therapy:

### Medication History for this Diagnosis

A. Is member currently treated on this medication?
☐ yes; How Long? _____ [go to item B] ☐ no [skip items B & C; go to item D]

B. Is this request for continuation of a previous approval?
☐ yes [go to item C] ☐ no [skip item C; go to item D]

C. Has strength, dosage, or quantity required per day increased or decreased?
☐ yes [go to item D] ☐ no [skip item D; indicate rationale for continuation in Section IV and submit form]

D. Please indicate previous treatment and outcomes below.

| **Drug Name (include strength and dosage)** | **Dates of Therapy** | **Reason for Discontinuation** |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. The **Buckeye Health Plan Preferred Drug List (PDL)** is available on the **Buckeye Health Plan** website at **www.buckeyehealthplan.com**.

## IV. Rationale for Request / Pertinent Clinical Information (Required for all Prior Authorizations)

| Appropriate clinical information to support the request on the basis of medical necessity must be submitted. | Provider Signature: | Date: |
|---|---|---|

Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, except during weekends and holidays. Requests for prior authorization (PA) must include member name, ID#, and drug name. **Incomplete forms will delay processing**. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)

***Contact Buckeye Health Plan at 1.866.246.4356 for Biopharmaceutical Products***
***This form is to be used for Medicaid members only***