



MEDICAID SPECIALTY MEDICATION PRIOR AUTHORIZATION FORM

Fax form to **1-866-704-3066**
Buckeye Health Plan, Pharmacy Department at
For questions, please call 1-866-246-4356

MEMBER INFORMATION		PRESCRIBER INFORMATION			
Member ID #:		Name:			
First Name:		Specialty:			
Last Name:		NPI #:			
Date of Birth		TIN #:			
Street Address:		Group or Hospital:			
City, State, Zip:		Street Address:			
Height:		City, State, Zip:			
Weight:		Phone:			
		Fax:			
		Contact Name:			
SERVICING PROVIDER/MEDICATION SUPPLIER					
Site of Administration: <input type="checkbox"/> Prescribing Physician's Office <input type="checkbox"/> Non-Prescribing Physician's Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Home Infusion <input type="checkbox"/> Other: _____					
Location Name:					
Location NPI:					
Location TIN:					
Phone:			Contact Name:		
INSURANCE INFORMATION					
Primary Insurance:			Secondary Insurance:		
ID Number:			ID Number:		
Phone Number:			Phone Number:		
DIAGNOSIS					
Diagnosis Date:		Diagnosis:		ICD 10:	
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION. NOTE: Include diagnostic clinicals (labs, radiology, etc.). Chemotherapy and supportive medication requests for adults should be sent directly to New Century Health.					
A. Is the member currently treated with this medication? <input type="checkbox"/> YES; How long? [go to item B] <input type="checkbox"/> NO; [skip item B and C]					
B. Is this request a continuation of a previous approval by Buckeye Health Plan? <input type="checkbox"/> YES; [go to item C] <input type="checkbox"/> NO; [skip item C]					
C. The strength, dosage, or quantity required per day has: <input type="checkbox"/> INCREASED <input type="checkbox"/> DECREASED <input type="checkbox"/> REMAINED THE SAME					
MEDICATION REQUESTED					
HCPCS & Medication Name	Strength/ Dose	Directions	QTY	Refills	Therapy Start Date

Prescriber's Signature _____ **Date:** _____

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