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: ☐ **Prescribing Physician's Office** ☐ **Non-Prescribing Physician's Office** ☐ **Hospital Outpatient** ☐ **Home Infusion** ☐ **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?

☐ YES; How long? [go to item B] ☐ NO; [skip item B and C]

B. Is this request a continuation of a previous approval by Buckeye Health Plan?

☐ YES; [go to item C] ☐ NO;[skip item C]

C. The strength, dosage, or quantity required per day has:

☐ INCREASED ☐ DECREASED ☐ REMAINED THE SAME

MEDICATION REQUESTED

HCPCS & Medication Name	Strength/ Dose	Directions	QTY	Refills	Therapy Start Date

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