

Pharmacy Pre-authorization Form: Physician Administered Drugs**Note: USE THIS FORM ONLY when seeking pre-authorization for coverage of prescriptions for PHYSICIAN ADMINISTERED DRUGS.**

Date: _____ Physician Name: _____
 Member Name: _____ Physician Specialty: _____
 Member ID Number: _____ Physician Address: _____
 Member Age: _____ Physician Telephone: _____
 Physician Fax/E-mail: _____

Please provide all requested information. INCOMPLETE FORMS will be returned for additional information.

Medication requested: _____

Provide the dose, frequency and expected duration of treatment: _____

Diagnosis: _____

Other medications used to treat condition and dates used: _____

Please provide the location where the patient will receive this treatment if approved:

 Physicians' Office (provide address if different than noted above)
 _____ Hospital Outpatient (provide hospital name and address)
 _____ Home (provide name of home care agency)
 _____**For ConnectiCare Use Only**

Date reviewed: _____

Approved/denied (circle one) by: _____ Approval expiration date*: _____

Comments: _____

** If the physician wishes to request further continuation of the pre-authorization for a period of time that exceeds the approved expiration date, the physician will need to supply clinical information to support the need. Authorizations are not given for >1 year. If required, submit an extension request prior to the end of the authorization period.*

**ConnectiCare Pharmacy Services: FAX — 1-800-249-1367, or e-mail — pharmacy@connecticare.com
 To speak to a Medical Director or Pharmacist regarding a pre-authorization decision, call 1-800-828-3407.**

*This is confidential information. If you receive this form in error, please notify Provider Services immediately at 1-800-828-3407.
 The information in this document does not apply to ConnectiCare VIP Medicare plan members.*