

Medicare: Physician Administered Drug Pre-authorization Request Form

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: _____

Please 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:

MD office-please provide address if different from above

Hospital outpatient-please provide hospital name & address

Home-please provide name of home care agency

For ConnectiCare Use Only:

Date reviewed: _____

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

Billing Code(s) Approved:

Comments: _____

**Please fax completed forms to ConnectiCare Pharmacy Services at (800) 249-1367
To speak to a Medical Director or Pharmacist regarding a pre-authorization decision, call 1-800-224-2273.**

This is confidential information. If you receive this form in error, please notify VIP Provider Services at 1-800-224-2273