Medicare Pharmacy Preauthorization Form: Physician-Administered Drugs

Date: ______________________________

Member Name: ______________________________

Member ID Number: ______________________________

Member DOB: ______________________________

Physician Name: ______________________________

Physician ID # (Required for all requests):

____

Physician Specialty: ______________________________

Physician Address: ______________________________

Physician Telephone: ______________________________

Physician Fax/Email: ______________________________

Medication requested: ______________________________

Provide the dose, frequency and expected duration of treatment:

Dose: ______________________________ Frequency: ______________________________

Expected Dates of Treatment: FROM: ______________________________ TO: ______________________________

Diagnosis: ______________________________

Other medications used to treat condition and dates used:

Drug name: ____________________ Date from: ______________ Date to: ______________
Drug name: ____________________ Date from: ______________ Date to: ______________
Drug name: ____________________ Date from: ______________ Date to: ______________

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

☐ Physicians' Office (provide address if different than noted above)

____

☐ Hospital Outpatient or Facility (provide hospital name and address)

____

☐ Home (provide name of home care agency)

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Please provide chart documentation of drug name(s), dates, duration of therapy and outcome.

** If the physician wishes to request further continuation of the preauthorization 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 more than 1 year. If required, submit an extension request prior to the end of the authorization period.*

ConnectiCare Medicare Pharmacy Services: FAX — 1-877-243-4812.
To speak to a Medical Director or Pharmacist regarding a preauthorization decision, call 1-888-447-0295.

This is confidential information. If you receive this form in error, please notify Provider Services immediately at 1-877-224-8230.