

Send To: AcariaHealth
 Specialty Pharmacy Provider: _____

**Prior Authorization Form
Specialty Drug**



Phone: 1-800-218-7453 x22080
Fax: 1-866-683-5631

Date: _____ Date Medication Required: _____

Patient Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: (____) _____ - _____ Alt. Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Patient Soc. Sec #: XXX-XX-_____ Date of Birth: ____/____/____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg Height: _____ BSA: _____ m ² County: _____	Physician Name: _____ StateLic# _____ DEA # _____ NPI # _____ UPIN# _____ Practice Name/Hospital: _____ Specialty: _____ Address: _____ City: _____ State: _____ Zip: _____ Physician's Phone: (____) _____ - _____ Physician's Fax: (____) _____ - _____ Nurse/Key Office Contact: _____ Direct Ext: _____
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INSURANCE INFORMATION (Please copy and attach the front and back of insurance and prescription drug card)

Prescription Card:	Name of Insurer: _____	ID#: _____	BIN: _____	PCN: _____	Group: _____
Primary Insurance:	Subscriber: _____	ID#: _____	Name of Insurer: _____	Tel #: _____	
Secondary Insurance:	Subscriber: _____	ID#: _____	Name of Insurer: _____	Tel #: _____	

DIAGNOSIS (Required)

What is the ICD-10 code? _____

PATIENT EVALUATION

1. Is the member currently treated with this medication?
 Yes; if yes please continue
 No; if no please continue to question #4
2. How long has the patient been on treated with this medication: _____ years months
3. Has the patient had a positive outcome? Yes No
4. Please indicate previous treatments and outcomes?

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
4.		

NOTE: confirmation of use will be made from member history on file; prior use of preferred drugs is part of the exception criteria

5. Please state Rationale for Request / Pertinent Clinical Information (Required for all prior authorizations)

****NOTE: We can NOT make a decision without a copy of pertinent lab results and/or the current clinical progress notes - Thank You****

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Physician's Signature: _____ Date: ____/____/____

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the name addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the name addressee, except by express authority of sender to the name addressee.