illinicare health

Phone: 866-329-4701
Fax: 855-217-0926

Send To: ❍ AcariaHealth
❍ Specialty Pharmacy Provider:_____
Date: _____ Date Medication Required:_____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Prior Authorization Form
General

Patient Name: _____	Physician Name: _____
Address: _____	State Lic #_____ DEA # _____
City: _____ State: _____ Zip:_____	NPI # _____ Specialty: _____
Home Phone: (_____) _____ - _____	Practice Name/Hospital: _____
Work Phone: (_____) _____ - _____	Address: _____
Cell Phone: (_____) _____ - _____	City: _____ State: _____ Zip: _____
Patient Soc. Sec #: _____ Allergies:_____	Physician's Ph: (_____) _____ - _____
Date of Birth: ___/___/___ Sex: ❍ Male ❍Female Weight _____ ❍lbs ❍kg	Physician's Fax: (_____) _____ - _____
Height: _____ BSA: _____ m² ❍See attached demographic sheet	Nurse/Key Office Contact: _____

INSURANCE INFORMATION (Complete or Attach Copies of cards)

Primary Insurance:_____	Secondary Insurance:_____	Rx Card (PBM):_____	Cardholder First Name: _____
City:_____State:_____	City:_____State:_____	PBM BIN: _____	Last Name: _____
Plan #: _____	Plan #: _____	City:_____State:_____	Employer: _____
Group #: _____	Group #: _____	Group #: _____	ID #: _____
Phone: (_____) _____-_____	Phone: (_____) _____-_____	Phone: (_____) _____-_____	Group #: _____

DIAGNOSIS *(Required)*

What is the ICD 9 / 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: _____ ❍ DAW (Dispense as Written) Date____/_____/____