Peach State Health Plan™

SPECIALTY MEDICATION PRIOR AUTHORIZATION FORM

Complete this form and send information to
Peach State Health Plan, Pharmacy Department
fax at **1-866-374-1579**
For questions, please call **800-514-0083 option 2**

Caremark Ship to: ☐ Patient ☐ Other **OR** ☐ **Dispense from Office, Hospital, or Outpatient Center Stock**

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, St Zip: _____
Home Phone: _____
Alternate Phone: _____
Date of Birth: _____
Gender: _____

OTHER SHIPPING LOCATION INFORMATION

Name: _____
Address: _____
City, St Zip: _____
Phone: _____
Fax: _____
Contact Name: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Specialty: _____
NPI#: _____
Group or Hospital: _____
Address: _____
City, St Zip: _____
Phone: _____
Fax: _____
Contact Name: _____

Name of Location Medication to be Supplied from if not shipped by Caremark: _____
Phone: _____
Fax: _____
Contact Name: _____

INSURANCE INFORMATION

Primary Insurance: _____ **ID#:** _____ **Phone#:** _____
Secondary Insurance: _____ **ID#:** _____ **Phone#:** _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis (please include ICD9 and description):

_____

Date of Diagnosis: _____ **Please include any diagnostic clinicals such as labs, radiology, exams, etc to support diagnosis**
For Chemotherapy Medication Requests, please include **Chemotherapy Regimen and Anticipated Dates of Service Requested**

Is member currently treated with this medication(s)? No ____ Yes _____ How long: _____
Is this request a continuation of a previous approval by Peach State? No ____ Yes ____
Has the strength, dosage or quantity required per day: Increased _____ Decreased _____ Same _____

MEDICATION(S) REQUESTED

Medication Name	Strength/Dose	Directions	QTY	Refills	Therapy Start Date

_____ _____
Prescriber's Signature **Date**