Ohio Medicaid Managed Care
Pharmacy Prior Authorization Request Form

☐ **AMERIGROUP**	☐ **Buckeye Community Health Plan**	☐ **CareSource Ohio**	☐ **Molina Healthcare of Ohio**
FAX: 800-359-5781	**FAX: 866-399-0929**	**FAX: 866-930-0019**	**FAX: 800-961-5160**
Phone: 800-454-3730	Phone: 866-399-0928	Phone: 800-488-0134	Phone: 800-642-4168
☐ **Paramount**	☐ **Unitedhealthcare Community Plan**	☐ **Wellcare**	
FAX: 419-887-2028	**FAX: 866-940-7328**	**FAX: 877-277-6892**	
Phone: 800-891-2520	Phone: 800-310-6826	Phone: 800-678-3184	

Patient Information

Patient Name	DOB		Date
Patient ID #	Sex	Medication Allergies	
Pharmacy	Pharmacy Phone		
For Injectables Only: Facility Name	For Injectables Only: Facility NPI #		

Provider Information

Prescriber Name	NPI #	DEA #
Prescriber Specialty	Prescriber Address	
Office Fax	Phone	Office Contact Name

Medication Requested

Drug Name	Strength	Dose	Directions (Sig)
Duration : Days: ______ Months: ______	Quantity	Refills	Diagnosis
Is the Patient currently treated on this medication?	☐ Yes; How Long______________		☐ No

Patient Previous Medication(s) Relevant to this Request*

Please indicate previous treatment and outcomes below

Drug Name	Strength	Dose	Directions	Duration & Reason for Discontinuation
1				
2				
3				
4				
5				

Relevant Medical Rationale for Request/Additional Clinical Information (Including diagnostic studies and lab results)*

Provider Signature	Date

In order to process this request, please complete all boxes completely and attach relevant notes when appropriate.