Ohio Medicaid Managed Care
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) Relevent 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 attached relevant notes when appropriate.