



Ohio Medicaid Managed Care Prior Authorization Request Form

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|---|--|--|--|
| <input type="checkbox"/> AMERIGROUP
FAX: 800-359-5781
Phone: 800-454-3730 | <input type="checkbox"/> Buckeye Community Health Plan
FAX: 866-399-0929
Phone: 866-399-0928 | <input type="checkbox"/> CareSource Ohio
FAX: 866-930-0019
Phone: 800-488-0134 | <input type="checkbox"/> Molina Healthcare of Ohio
FAX: 800-961-5160
Phone: 800-642-4168 |
| <input type="checkbox"/> Paramount
FAX: 419-887-2028
Phone: 800-891-2520 | <input type="checkbox"/> Unitedhealthcare Community Plan
FAX: 866-940-7328
Phone: 800-310-6826 | <input type="checkbox"/> Wellcare
FAX: 877-277-6892
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? <input type="checkbox"/> Yes; How Long _____ <input type="checkbox"/> 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)*

<table border="0" style="width: 100%;"> <tr> <td style="width: 70%;">Provider Signature</td> <td style="width: 30%;">Date</td> </tr> </table>	Provider Signature	Date
Provider Signature	Date	

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