



INJECTABLE 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 Office Other: _____ OR Office Stock Use

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____ Address: _____ City, St Zip: _____ Home Phone: _____ Alternate Phone: _____ Date of Birth: _____ Gender: _____	Prescriber Name: _____ NPI#: _____ Group or Hospital: _____ Address: _____ City, St Zip: _____ 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.	Additional Clinical Information: <ul style="list-style-type: none"> • Weight: _____ kg/lbs • Height: _____ in/cm • Lab Data (Please include copies of reports): _____ _____ • Other Medications: _____ _____ • Additional Comments: _____ _____
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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				Therapy Start Date: _____	
Rx	Medication Name	Strength/Dose	Directions	Quantity	Refills

Prescriber's Signature

Date

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