<u>SPECIALTY MEDICATION</u>
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

ACARIA 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 ACARIA: __________
Phone: ___________________________________
Fax: _____________________________________
Contact Name: ______________________________

INSURANCE INFORMATION
Primary Insurance: ________________________ ID#: ______________________ Phone#: ____________
Secondary Insurance: ______________________ ID#: ______________________ Phone#: ____________

STATEMENT OF MEDICAL NECESSITY

Diagnosis (please include ICD10 and description):

Date of Diagnosis: _____ **Please include any diagnostic clinicals such as labs, radiology, exams, etc to support diagnosis**

For Chemotherapy Medication Requests, please request online at www.eviti.com

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 _______

Rx **MEDICATION(S) REQUESTED**

Medication Name	**Strength/Dose**	**Directions**	**QTY**	**Refills**	**Therapy Start Date**

____ ____________________
Prescriber's Signature **Date**

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