

Pharmacy Pre-authorization Form: General Requests

Note: DO NOT USE THIS FORM for pre-authorization requests for PROTON PUMP INHIBITORS, ARB'S, CIMZIA, HEPATITIS C, HYALURONIC ACIDS, MIGRAINE MEDICATIONS, SEDATIVE HYPNOTICS, TESTOSTERONE REPLACEMENTS, ANTIDEPRESSANTS, STATINS, PHYSICIAN ADMINISTERED DRUGS, or INFERTILITY TREATMENTS. Please use the specific form for these drugs, found online at www.connecticare.com.

Date: _____ Physician Name: _____
Member Name: _____ Physician ID # (Required for all requests) _____
Member ID Number: _____ Physician Specialty: _____
Member DOB: _____ Physician Address: _____
Physician Telephone: _____
Physician Fax/E-mail: _____

Medication requested: _____

Dose/expected duration of treatment: _____

Diagnosis: _____ ICD9/ICD10 Code _____

THIS CODE IS NOW REQUIRED ON ALL REQUESTS per Patient Protection and Affordable Care Act.

Reason for request (please be as specific as possible): _____

Additional Pertinent Information: _____

Other medications used to treat condition and dates used: _____

PLEASE NOTE: If pharmacy claims are not found, chart notes may be required to verify past medication trials

PRESCRIBER SIGNATURE _____ DATE _____
By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

For ConnectiCare Use Only

Date reviewed: _____

Approved/denied (circle one) by: _____ Approval expiration date: _____

Comments: _____

Code: _____

ConnectiCare Pharmacy Services: FAX — 1-800-249-1367

To speak to a Medical Director or Pharmacist regarding a pre-authorization decision, call 1-800-828-3407.

This is confidential information. If you receive this form in error, please notify Provider Services immediately at 1-800-828-3407. The information in this document does not apply to ConnectiCare VIP Medicare plan members.