

## MEDICATION PRIOR AUTHORIZATION REQUEST FORM

Is the request for a **SPECIALTY MEDICATION** or BUY & BILL? ☐ YES (Buy and Bill Medication Request) → Complete this form and fax to 1-855-690-5433. For questions, call (855) 650-3789. ☐ YES (Specialty Pharmacy Medication Request) → Do NOT Use this form. Complete the drug-specific form on the Home State Health website and fax to number listed on the respective form. NO (Non-Specialty Medication Request) → Do NOT Use this form. Complete the Prior Authorization Request Form for Non-Specialty Drugs on the Home State Health website and fax to the number listed on the respective form. TODAY'S DATE: \_\_\_\_ I. MEMBER INFORMATION (\*REQUIRED FIELDS) II. PRESCRIBER INFORMATION (\*REQUIRED FIELDS) \*Name: \*Name: ID Number: Specialty: \*NPI or DEA Number: Gender: \*Date of Birth: Group or Hospital: Address: Address: City, State, Zip: City, State, Zip: \*Phone: Primary Phone: \*Fax: Alternate Phone: Office Contact Name: Medication Allergies: Member's Height: Additional Pertinent Provider Information: Member's Weight: kg / lb. (circle one **III. Drug Information** (only ONE drug request per form) (\*REQUIRED FIELDS) \*HCPCS (if buy and bill): \*Drug Name: \*Strength: \*Dosage Form: \*Directions for Use (sig): \*Therapy Start Date: \*Therapy End Date: IV. DIAGNOSIS (as relevant to this request) (\*REQUIRED FIELDS) Diagnosis: \*ICD10: Date of Diagnosis: NOTE: Include diagnostic clinicals (labs, radiology, etc.). V. MEDICATION HISTORY (for this diagnosis) A. Is the member currently on this medication?  $\square$  Yes; if yes, how long?  $\square$ No; if no, skip items B&C, go to D. B. Is this a request for continuation of a previous approval?  $\square$  Yes; if yes, go to item C.  $\square$  No; if no, skip item C, go to D.

D. Indicate PREVIOUS medications treatment/outcomes below. NOTE: Confirmation will be made using claims history.

☐ DECREASED:

☐ Remained the same

C. Has the strength, dosage, or quantity required per day:  $\square$ INCREASED:

Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
4.		
VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION  NOTE: Appropriate clinical information to support this request is required for all PA's. Attach additional sheets if more space is needed.		
Prescriber Signature		
X	Date:	

Please access <a href="www.HomeStateHealth.com">www.HomeStateHealth.com</a> or contact provider services for a current listing of preferred products.

\*REQUIRED FIELDS - PA requests with missing/incomplete required fields may be returned as an invalid request. Valid requests also require appropriate clinical documentation to support the medical necessity of this request.