



Pharmacy Prior Authorization Form

Phone 602.778.1831
Fax 602.778.1838

Care1st Internal Use
Sub #:
DOE:
IPA:
LOB:

Instructions: Participating physicians and pharmacies use this form to obtain a medication that is not on the Formulary or requires prior authorization. Please complete the form and fax it to the Care1st/ONECare Pharmacy Department. For any questions regarding the Care1st or ONECare Formulary and/or medication prior authorization process, please call the Care1st/ONECare Pharmacy Department.

Patient Name: <i>(required)</i>		Patient ID#: <i>(required)</i>	
Patient Phone Number:	Patient Date of Birth:	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female

Pharmacy Name:	Pharmacy NABP Number: <i>(optional)</i>
Pharmacy Phone Number:	Pharmacy Fax Number: <i>(optional)</i>

Prescribing Physician's Name: <i>(required)</i> Dr.	Specialty: <i>(required)</i>
State License Number:	E-mail address: <i>(optional)</i>
Phone Number: <i>(required)</i>	Fax Number: <i>(required)</i>

Drug Requested: <i>(required)</i>	Strength: <i>(required)</i>	Formulation:	Quantity:	Days Supply:
Diagnosis: <i>(required)</i>		Duration of Therapy:		Refills:
Directions, sig or a copy of prescription: <i>(required)</i>				
Current Medications: <i>(required)</i>				
Previous Medication(s) Tried and Failed: <i>(required)</i>				
Medical Justification: <i>(required)</i>				
Signature of Requestor: <i>(required)</i>			Request Date:	
Contact Name: <i>(required - please print)</i>				

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