

MEDICATION PRIOR AUTHORIZATION REQUEST FORM

Is the request for a **SPECIALTY MEDICATION** or **BUY & BILL**?

- YES (Specialty Pharmacy Medication Request)** → Complete this form and fax to **(855) 678-6976**. For questions, call (800) 460-8988.
- YES (Buy and Bill Medication Request)** → Complete this form and fax to **(866) 351-7388**. For questions, call (866) 796-0530, ext. 41919.
- NO (Non-Specialty Medication Request)** → Do **NOT** Use this form. Complete the Prior Authorization Form - Non-Specialty Medication form on the Sunshine Health web-site ([Click Here](#)) and fax to **(866) 399-0929**. For questions, call (866) 399-0928.

TODAY'S DATE: _____

I. MEMBER INFORMATION [*REQUIRED FIELDS]	II. PRESCRIBER INFORMATION [*REQUIRED FIELDS]
*Name:	*Name:
ID Number:	Specialty:
Gender:	*NPI or DEA Number:
*Date of Birth:	Group or Hospital:
Address:	Address:
City, State, Zip:	City, State, Zip:
Primary Phone:	*Phone:
Alternate Phone:	*Fax:
Medication Allergies:	Office Contact Name:
Member's Height:	Additional Pertinent Provider Information:
Member's Weight: kg / lb (circle one)	

III. Drug Information <small>(only ONE drug request per form)</small> [*REQUIRED FIELDS]	
*HCPCS (if buy and bill):	*Drug Name:
*Strength:	*Dosage Form:
*Directions for Use (sig):	
*Therapy Start Date:	*Therapy End Date:

IV. DIAGNOSIS <small>(as relevant to this request)</small> [*REQUIRED FIELDS]	
Diagnosis:	*ICD10:
Date of Diagnosis:	<i>NOTE: Include diagnostic clinicals (labs, radiology, etc.).</i>

V. MEDICATION HISTORY <small>(for this diagnosis)</small>		
A. Is the member currently on this medication? <input type="checkbox"/> Yes; if yes, how long? _____ <input type="checkbox"/> No; if no, skip items B&C, go to D.		
B. Is this a request for continuation of a previous approval? <input type="checkbox"/> Yes; if yes, go to item C. <input type="checkbox"/> No; if no, skip item C, go to D.		
C. Has the strength, dosage, or quantity required per day: <input type="checkbox"/> INCREASED: _____ <input type="checkbox"/> DECREASED: _____ <input type="checkbox"/> Remained the same		
D. Indicate PREVIOUS medications treatment/outcomes below. <i>NOTE: Confirmation will be made using claims history.</i>		
Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
4.		

VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION
<i>NOTE: Appropriate clinical information to support this request is required for all PA's. Attach additional sheets if more space is needed.</i>

Prescriber Signature

X _____ Date: _____

Please access www.SunshineHealth.com 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.**