Pharmacy Pre-authorization Form: General Requests

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

Date:_____

Member Name:_____

Member ID Number:_____

Member DOB:_____

Physician Name:_____

Physician ID # (Required for all requests) _____

Physician Specialty:_____

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.

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.

The information in this document does not apply to ConnectiCare VIP Medicare plan members. PPM 5/19