Ohio Medicaid Managed Care
Pharmacy Prior Authorization Request Form

☐ **AMERIGROUP**
FAX: 800-359-5781
Phone: 800-454-3730

☐ **Buckeye Community Health Plan**
FAX: 866-399-0929
Phone: 866-399-0928

☐ **CareSource Ohio**
FAX: 866-930-0019
Phone: 800-488-0134

☐ **Molina Healthcare of Ohio**
FAX: 800-961-5160
Phone: 800-642-4168

☐ **Paramount**
FAX: 419-887-2028
Phone: 800-891-2520

☐ **Unitedhealthcare Community Plan**
FAX: 866-940-7328
Phone: 800-310-6826

☐ **Wellcare**
FAX: 877-277-6892
Phone: 800-678-3184

Patient Information

Patient Name		DOB	Date
Patient ID #		Sex	Medication Allergies
Pharmacy		Pharmacy Phone	
For Injectables Only: Facility Name		For Injectables Only: Facility NPI #	

Provider Information

Prescriber Name	NPI #	DEA #
Prescriber Specialty	Prescriber Address	
Office Fax	Phone	Office Contact Name

Medication Requested

Drug Name	Strength	Dose	Directions (Sig)
Duration : Days: _____ Months: _____	Quantity	Refills	Diagnosis

Is the Patient currently treated on this medication? ☐ Yes; How Long_____ ☐ No

Patient Previous Medication(s) Relevant to this Request*

Please indicate previous treatment and outcomes below

Drug Name	Strength	Dose	Directions	Duration & Reason for Discontinuation
1				
2				
3				
4				
5				

Relevant Medical Rationale for Request/Additional Clinical Information (Including diagnostic studies and lab results)*

Provider Signature	Date

In order to process this request, please complete all boxes completely and attached relevant notes when appropriate.