TRUECARE Specialty Pharmacy Prior Authorization Form

Medical Benefit Fax: 1-888-399-0271

Note: Illegible or incomplete forms will be returned. ☐ Urgent ☐ Standard

MEMBER INFORMATION	Member Name:		Date:
	Member ID:	Date of Birth:	Height:
	Medication Allergies:		Weight: ❑ lb. ❑ kg.
COORDINATION OF BENEFITS *(as applicable)*	Primary Insurance Name:		Secondary Insurance Name:
	ID #: Group #:		ID #: Group #:
MEDICATION INFORMATION	Drug Name & Strength:		HCPCS Code(s):
	Directions for Use:		Route of Administration:
	Dosage Form:		Date(s) of Service Requested: From: _____ To: _____
DIAGNOSIS FOR TREATMENT	Diagnosis Code(s):		Diagnosis Description(s):
DOCUMENTATION REQUIREMENT	Prior authorization requests without medical justification, required test results, etc. will be considered INCOMPLETE. Refer to the corresponding pharmacy policy at **MSTrueCare.com** for drug-specific requirements.		
MEDICATION HISTORY FOR DIAGNOSIS	A. Is member currently treated with this medication? ❑ YES; Start Date: ❑ NO		B. Is this request for continuation of a previous approval? ❑ YES; Start Date: ❑ NO
	C. Please document previous trials and treatments, including dates and outcomes below.		
	Drug Name	Dates of Therapy	Outcome/Reason for Discontinuation
ADDITIONAL NEEDS (list codes and units)	Home Nursing	Supplies	Other
			Note: Nursing and supplies will be considered a medical benefit

SERVICING PROVIDER INFORMATION	Place of Service: ❑ Prescriber's Office ❑ Out-Patient Facility ❑ Ambulatory Infusion Center ❑ Member's Home ☐ Pharmacy	Servicing Provider Name: Servicing Provider Address: City: State: Zip Code: Contact Name: Phone #: Fax #: TrueCare ID #: Tax ID #: NPI #:	Drug claim to be submitted to: ❑ Medical Benefit

PRESCRIBING PROVIDER INFORMATION	Prescriber Name:		Prescriber Specialty:
	Office Contact:	Phone #:	Fax #:
	Address:		
	City:	State:	Zip Code:
	TrueCare ID #:	Tax ID #:	NPI #:
	Prescriber Signature:		Date: