absolute total care
Healthy Connections

SPECIALTY MEDICATION PRIOR AUTHORIZATION FORM

Complete this form and send information to
Absolute Total Care, Pharmacy Department fax
at **1-855-865-9469**
For questions, please call **1-866-433-6041, ext. 64455**

ACARIA Ship to: ☐ Patient ☐ Other **OR** ☐ **Dispense from Office, Hospital, or Outpatient Center Stock**

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, St Zip: _____
Home Phone: _____
Alternate Phone: _____
Date of Birth: _____
Gender: ____ Height_____ Weight_____lb/kg

OTHER SHIPPING LOCATION INFORMATION

Name: _____
Address: _____
City, St Zip: _____
Phone: _____
Fax: _____
Contact Name: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Specialty: _____
NPI#: _____
Group or Hospital: _____
Address: _____
City, St Zip: _____
Phone: _____
Fax: _____
Contact Name: _____

Name of Location Medication to be Supplied from if not shipped by ACARIA: _____
Phone: _____
Fax: _____
Contact Name: _____

INSURANCE INFORMATION

Primary Insurance: _____ **ID#:** _____ **Phone#:** _____
Secondary Insurance: _____ **ID#:** _____ **Phone#:** _

STATEMENT OF MEDICAL NECESSITY

Diagnosis (please include ICD-10 and description): _____

Date of Diagnosis: _____ **Please include any diagnostic clinicals such as labs, radiology, exams, etc to support diagnosis**

Is member currently treated with this medication(s)? No ____ Yes_____How long: _____

Is this request a continuation of a previous approval by Absolute Total Care? No_____Yes _____
Has the strength, dosage or quantity required per day: Increased_____Decreased_____Same _____

Rx **MEDICATION(S) REQUESTED**

Medication Name	Strength/Dose	Directions	QTY	Refills	Therapy Start Date

_____ _____
Prescriber's Signature **Date**