COMMUNITY CARE ASSOCIATES INC.

PHARMACY DEPARTMENT

Fax # (313) 961-3116 Office # (313) 961-3100

PRIOR AUTHORIZATION FORM

REQUEST DATE:_____CONTACT NAME:_____

MEMBER NAME:_____PHONE #:_____

ID #: _____EFFECTIVE DATE:_____

DOB: _____

DRUG NAME: _____

DOSE: _____QTY#:_____REFILL (S): _____

PLEASE LIST OTHER MEDICATIONS CURRENTLY PRESCRIBED:

*DRUG LIST:

_____

_____

_____

DIAGNOSIS: _____

_____

_____

COMMENTS: _____

_____

_____

PCP: _____

Physician's Name: _____Phone #:_____

Pharmacy Name: _____Phone #:_____

APPROVED BY: _____Date: _____

Override/Exception Date Span: _____

Fax Number: _____

***ALL PRIOR AUTHORIZATION'S WILL REQUIRE PROGRESS NOTES FROM PATIENT'S MEDICAL CHART FOR THE SAID DIAGNOSIS.**

***INCOMPLETION OF THIS FORM AND MISSING PROGRESS NOTES WILL DELAY THIS PROCESS.**

Pharmacy clerk initials:_____