

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.**

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Pharmacy clerk initials: _____