Specialty Pharmacy Medical Request

Centrix Benefit Administrators,Inc.
PO Box 212199
Chula Vista, CA 91921

P Please refer to the phone number listed on the back of the member's ID card.
F (619) 220 - 9003
E support@centrixba.com

All relevant information must be completed. Centrix's receipt of this completed form does not constitute a guarantee of benefits.

When submitting a prior authorization request, please note the following information is necessary when applying criteria and determining medical necessity:

Copy of the Rx Order or Script. *(Required)*

Letter of Medical Necessity. *(Required)*

3-6 months of clinical information including medical history, physical exams and most current progress notes. *(Required)*

Current medications as well as medications that have been TRIED/FAILED. *(Required)*

Any **pertinent** lab work, including fecal occult blood test, culture reports, Hematocrit, Hemoglobin, Hormone studies and TSHs.

Any **pertinen**t imaging reports, such as U/S, X-rays, CTs.

Today's Date:			**Date Medication Needed:**	
Duration of Authorization: ☐ **1 Month** ☐ **3 Months** ☐ **6 Months** ☐ **12 Months** ☐ **Other**				
Request:				
☐ **Initial** ☐ **Continuation of Care** ☐ **Appeal**				
SECTION A - PATIENT INFORMATION				
Patient's First Name			**Patient's Last Name**	
Employee's First Name			**Employee's Last Name**	
Employee's SS#				
Address			**City**	**State** / **Zip**
Home Phone		**Work Phone**		**Cell Phone**
DOB	**Height**	**Weight**		**Allergies**
SECTION B - INSURANCE INFORMATION				
Primary Insurance			**Pharmacy Benefit Manager**	
ID #	**Group #**		**Insured**	**Phone**
Medicare? ☐ **Yes** ☐ **No**	**If yes, provide #**		**Medicaid?** ☐ **Yes** ☐ **No**	**If yes, provide #**
Secondary Insurance			**Pharmacy Benefit Manager**	
Policy #	**Group #**		**Insured**	**Phone**

SECTION C - PHYSICIAN INFORMATION

First Name				Last Name			
Address				**City**		**State**	**Zip**
Phone	**Fax**	**St Lic. #**		**NPI #**	**DEA #**		**UPIN**
Office Contact Name				**Phone**			

SECTION D - CURRENT MEDICAL INFORMATION ONLY

Primary Diagnosis	ICD-10 Code		Secondary Diagnosis		ICD-10 Code
Requested Medication Name	**Dose/Strength**	**Frequency**	**Directions**	**Quantity**	**# of Refills**
HCPCS/CPT Code	**Dose/Strength**	**Frequency**	**Directions**	**Quantity**	**# of Refills**
Tried and Failed Medications pertaining to request above.	**Dose/Strength**	**Frequency**	**Directions**	**Quantity**	**# of Refills**

SECTION E - BILLING AND SHIPPING INFORMATION

Is this Provider going to supply and bill for the medication?	☐ **Yes**	☐ **No**
If **YES**, is the Physician listed in section C the one billing for this medication?	☐ **Yes**	☐ **No**

If **NO**, please provide the name and phone number for the Physician or Facility supplying and billing for this medication.

Name: **Phone Number:**

Authorization Number (if required)

Administration Site:

☐ Physician's Office	☐ Patient's Home	☐ Home Care Agency	☐ Ambulatory Infusion Center
☐ Patient Administered Oral		☐ Patient Administered Injectable	

All required sections must be completed in full to ensure covered prescriptions ship within 3-7 business days. If these sections are not completed accurately, your order may be delayed.

Shipping: ***(If shipping is required, please complete below.)***

☐ Physician's Office	☐ Home Care Agency (name and address if available)
☐ Patient's Home	☐ Ambulatory Infusion Center (location address)

Prescriber's Signature (required by law) Date