

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 pertinent 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 I		onths	Other	
Request:									
Initial	Continuation of Care			Appeal	vppeal				
				SECTION A - PAT	IENT INFORMATIO	N			
					T				
Patient's First Name					Patient's Last Nar	ne			
Employee's First Name				Employee's Last I	Name				
Employee's SS#									
Address				City		State	Zip		
Home Phone				Work Phon	e Cell Phone				
				Weight					
DOB	Height					Allergies			
			c		RANCE INFORMAT				
			U						
Primary Insurance				Pharmacy Benefit Manager					
ID #			Group #		Insured		Phone		
				I					
Medicare?		lf yes, p	rovide #		Medicaid?		If yes, provide #	#	
Yes	No				Yes	No			
Secondary Insurance				Pharmacy Benefit Manager					
							1	1	
Policy #			Group #		Insured		Phone		

		\$	SECTI	ON C - PHYS	ICIAN INFORMATION				
First Name		Last Name							
Address				City		State		Zip	
Phone	Fax	C+	lic #		NPI #	DEA #			UPIN
		St Lic. #			NPI# DEA#				OFIN
Office Contact Name			1		Phone				
		SECTIO	N D - (CURRENT ME	EDICAL INFORMATION ON	LY			
								1	
Primary Diagnosis		ICD-10 Code	е		Secondary Diagnosis		ICD-10 Code		
Requested Medication I	Name	Dose/Strei	ngth	Frequency	Directions		Quantity		# of Refills
		Dece/Street	un extela	F	Directions		0		# of Dofillo
HCPCS/CPT Code		Dose/Strength		Frequency	Directions		Quantity		# of Refills
Tried and Failed Medications pertaining to request above.		Dose/Strength		Frequency	Directions		0112	ntity	# of Refills
pertaining to request at	Jove.	Dose/Strei	ngui	Frequency	Directions		Qua	intity	# Of Refills
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Is this Provider going to	o supply and bill							Yes	No
Is this Provider going to If YES, is the Physicia		for the medi	ication	1?				Yes Yes	No
If YES , is the Physicia	n listed in section	for the medi	ication	1? r this medicati			edication	Yes	-
If YES , is the Physicia	n listed in section	for the medi	ication	1? r this medicati	on? acility supplying and billing f	or this m	edication	Yes	-
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