



**MEDICATION PRIOR AUTHORIZATION
REQUEST FORM**



Is the request for a **SPECIALTY MEDICATION** or **BUY & BILL**?

- YES (Buy and Bill Medication Request)** → Complete this form and fax to **1-866-351-7388**. For questions, call (866) 796-0530, ext 41919.
- YES (Specialty Pharmacy Medication Request)** → Do **NOT** Use this form. Complete the drug-specific form on the Sunshine Health website ([Click Here](#)) and fax to number listed on the respective form. For questions, call (800) 511-5144.
- NO (Non-Specialty Medication Request)** → Do **NOT** Use this form. Complete the Prior Authorization Request Form for Non-Specialty Drugs on the Sunshine Health website ([Click Here](#)) and fax to the number listed on the respective form. For questions, call (866) 399-0928.

TODAY'S DATE: _____

I. MEMBER INFORMATION (*REQUIRED FIELDS)		II. PRESCRIBER INFORMATION (*REQUIRED FIELDS)	
*Name:		*Name:	
ID Number:		Specialty:	
Gender:		*NPI or DEA Number:	
*Date of Birth:		Group or Hospital:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Primary Phone:		*Phone:	
Alternate Phone:		*Fax:	
Medication Allergies:		Office Contact Name:	
Member's Height:		Additional Pertinent Provider Information:	
Member's Weight:	kg / lb (circle one)		
III. Drug Information (only ONE drug request per form) (*REQUIRED FIELDS)			
*HCPCS (if buy and bill):		*Drug Name:	
*Strength:		*Dosage Form:	
*Directions for Use (sig):			
*Therapy Start Date:		*Therapy End Date:	
IV. DIAGNOSIS (as relevant to this request) (*REQUIRED FIELDS)			
Diagnosis:		*ICD10:	
Date of Diagnosis:		NOTE: Include diagnostic clinicals (labs, radiology, etc.).	
V. MEDICATION HISTORY (for this diagnosis)			
A. Is the member currently on this medication? <input type="checkbox"/> Yes; if yes, how long? _____ <input type="checkbox"/> No; if no, skip items B&C, go to D.			
B. Is this a request for continuation of a previous approval? <input type="checkbox"/> Yes; if yes, go to item C. <input type="checkbox"/> No; if no, skip item C, go to D.			
C. Has the strength, dosage, or quantity required per day: <input type="checkbox"/> INCREASED: _____ <input type="checkbox"/> DECREASED: _____ <input type="checkbox"/> Remained the same			
D. Indicate PREVIOUS medications treatment/outcomes below. NOTE: Confirmation will be made using claims history.			
Drug Name, Strength, and Dosage		Dates of Therapy	Reason for Discontinuation
1.			
2.			
3.			
4.			
VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION			
NOTE: Appropriate clinical information to support this request is required for all PA's. Attach additional sheets if more space is needed.			

Prescriber Signature

X _____

Date: _____

Please access www.SunshineHealth.com or contact provider services for a current listing of preferred products.

***REQUIRED FIELDS - PA requests with missing/incomplete required fields may be returned as an invalid request. Valid requests also require appropriate clinical documentation to support the medical necessity of this request.**