CAREAssist
AUTHORIZATION REQUEST FORM

Provider Services: 888-311-7632 **Fax Form to:** 800-848-4241 or 510-587-2799

PLEASE REVIEW REQUEST FOR ACCURACY AND COMPLETE ALL APPROPRIATE

PHARMACY INFORMATION

NPI: _____

Contact person:: _____

STAMP or **WRITE** Pharmacy Name, Phone & Fax:

PHONE: ( ) _____

FAX: ( ) _____

CLIENT INFORMATION

(Print Clearly)

_____

Last Name First Name

I.D.: _____

D.O. B. _____ / _____ / _____

			Co-Pay or Cash Price	Requested QTY	Days Supply	Prescription Date
RX#1	_____	NDC : _____-_____-_____	$: _____		_____	_____
RX#2	_____	NDC : _____-_____-_____	$: _____		_____	_____
RX#3	_____	NDC : _____-_____-_____	$: _____		_____	_____
RX#4	_____	NDC : _____-_____-_____	$: _____		_____	_____
RX#5	_____	NDC : _____-_____-_____	$: _____		_____	_____
RX#6	_____	NDC : _____-_____-_____	$: _____		_____	_____
RX#7	_____	NDC : _____-_____-_____	$: _____		_____	_____
RX#8	_____	NDC : _____-_____-_____	$: _____		_____	_____
RX#9	_____	NDC : _____-_____-_____	$: _____		_____	_____

MUST CHECK ALL THAT APPLY!

BRIDGE REQUESTS:

☐ 2nd fill on extension of benefits

CAREAssist REQUESTS:

PROOF OF BILLING MUST ACCOMPANY THIS REQUEST

Program Limits

☐ Claim over 90 days
☐ Max copayment override
☐ Reversal request

Quantity limit

☐ CII or CII Max* **original Rx required*
☐ ARV Daily QTY Max** ***Submit w/Treatment Exception Request (TER) form*
☐ Day supply >30 with copay
☐ Less than minimum required
☐ Lost Max fills (13) per year met

Early Refill

☐ Lost med fill
☐ Vacation Supply
☐ Change in dose* **original Rx required*

Other

☐ DAW _____
☐ Other Coverage Code _____

NOTES/EXPLANATION: