PARAMOUNT
Affiliate of ProMedica

PRIOR AUTHORIZATION REQUEST
INFUSED AND INJECTABLE SPECIALTY DRUGS

Please Fax Form to: 1-844-256-2025

Physician/Providers Inquiry only: **1-800-891-2520,** Option 2

MEMBER NAME: _____ Date of Request: _____

Paramount Member ID Number: _____ DOB: _____ Diagnosis/ICD-9: _____

PROVIDER NAME: _____ ***SIGNATURE***: _____

Provider Address: _____ Provider ID: _____

Phone: _____ Fax: _____ Contact Name: _____

PARAMOUNT MEMBER IS ENROLLED IN:

❑ *Commercial plans* ❑ *Paramount Marketplace™* (Exchange) ❑ *Paramount Advantage™* (Ohio Medicaid)

DRUG/DOSAGE/ROUTE/FREQUENCY REQUESTED*: _____

Patient Information (*REQUIRED* for dosing): Ht. _____ **Wt.** _____ (lbs / kg) **BUN/SCr** _____

Please see the **Paramount Specialty Drug List for those injectable or infused drugs that require prior authorization.*

PHARMACY SUPPLYING SELF-ADMINISTERED DRUGS:

If self-administered, please indicate which **Paramount Specialty Network Pharmacy** will provide the drug to the member. If the drug is not available through the Paramount Specialty Network, then please indicate the limited distribution pharmacy used.

❑ Flower Hospital Outpatient Pharmacy
❑ Fostoria Community Hospital Pharmacy
❑ The Pharmacy Counter *(all locations)*
❑ Toledo Clinic Pharmacy
❑ Toledo Hospital Outpatient Pharmacy
❑ West Central Outpatient Pharmacy
❑ CuraScript
❑ Accredo

MEDICAL/CLINICAL HISTORY:

Therapeutic Indication/Diagnosis and Code _____

Duration of Treatment _____

Current Signs and Symptoms (*attach lab values, as appropriate*): _____

_____

_____

Previous Treatments/Therapies and Results (*attach supporting documentation (i.e. history), as appropriate)*:

_____

_____

_____