sunshine health
Stars & Stars Plus

MEDICATION PRIOR AUTHORIZATION REQUEST FORM

USscript
Integrity. Innovation. Outcomes.

Is the request for a **SPECIALTY MEDICATION**?

☐ **YES** ⟶ Do NOT use this form for your **SPECIALTY MEDICATION** request.
Complete the DRUG SPECIFIC (link) form OR the GENERAL ENROLLMENT (link) form if the drug is not listed.
NOTE: Forms are available on the Sunshine Health website at www.SunshineHealth.com.

☐ **NO** ⟶ Complete **THIS** form and FAX to **1-866-399-0929**

TODAY'S DATE: _____

I. MEMBER INFORMATION		**II. PRESCRIBER INFORMATION**	
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:	

IV. MEDICATION REQUESTED (only ONE medication request per form)			
Drug Name:		Dosage/Strength:	
Dosage Form:		Route of Admin:	
Quantity Per Day:		Directions:	
Refills/Length of Tx:		Therapy Start Date:	

V. DIAGNOSIS (as relevant to this request)			
Diagnosis:		ICD10:	
Date of Diagnosis:		*NOTE: Include diagnostic clinicals (labs, radiology, etc.).*	

VII. MEDICATION HISTORY (for this diagnosis)

A. Is the member currently on this medication? ☐Yes; if yes, how long? _____ ☐No; if no, skip items B&C, go to D.

B. Is this a request for continuation of a previous approval? ☐Yes; if yes, go to item C. ☐No; if no, skip item C, go to D.

C. Has the strength, dosage, or quantity required per day: ☐INCREASED: _____ ☐DECREASED: _____ ☐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			

VIII. 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 – Dispense as Written (DAW):
X_____ Date: _____

Prescriber Signature – Substitution Permitted:
X_____ Date: _____

Please access www.SunshineHealth.com or contact provider services for a current listing of preferred products. A response will be provided via fax or phone within 24 hours of receipt of the request. Incomplete and illegible forms will delay processing. Be sure to include lab reports with requests when appropriate. **To request a 72 hour emergency supply of medication you may call US Script at 1-877-397-9526.** *NOTE: The 72 hour supply does not apply to specialty medications.* Requests can also be mailed to: US Script, Attention: Prior Authorization Department, 2425 West Shaw Avenue, Fresno, California 93711.