

# Pharmacy Pre-authorization Request Form

**\*Note: Please use specific forms available on the provider website when prescribing the following drugs:  
Proton Pump Inhibitors (i.e. Aciphex, Nexium, omeprazole, Prevacid, Protonix), Non-sedating antihistamines (i.e. Allegra, Clarinex, Zyrtec, incl. Singulair), Celebrex, Statins (i.e. Lipitor, Vytorin) and Infertility Treatments**

Date: \_\_\_\_\_ Physician Name: \_\_\_\_\_  
Member Name: \_\_\_\_\_ Physician Specialty: \_\_\_\_\_  
Member ID Number: \_\_\_\_\_ Physician Address: \_\_\_\_\_  
Member Age: \_\_\_\_\_ Physician Telephone: \_\_\_\_\_  
Physician Fax/E-mail: \_\_\_\_\_

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*Please provide all requested information. Incomplete forms will be returned for additional information.*

Medication requested: \_\_\_\_\_  
Dose/expected duration of treatment: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Reason for request (please be as specific as possible): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Other medications used to treat condition and dates used: \_\_\_\_\_  
\_\_\_\_\_

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### For ConnectiCare Use Only:

Date reviewed: \_\_\_\_\_  
Approved/denied (circle one) by: \_\_\_\_\_ Approval expiration date\*: \_\_\_\_\_  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*\*If the physician wishes to request further continuation of the pre-authorization for a period of time that exceeds the approved expiration date, the physician will need to supply clinical information to support the need. Authorizations are not given for >1 year. If required, submit an extension request prior to the end of the authorization period.*

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**ConnectiCare Pharmacy Services: fax - (860) 674-2851, or e-mail - [pharmacy@connecticare.com](mailto:pharmacy@connecticare.com)  
To speak to a Medical Director or Pharmacist regarding a pre-authorization decision, call 1-800-828-3407.**

*This is confidential information. If you receive this form in error, please notify Provider Services at 1-800-828-3407*