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| **Member Name:**       |  |  | **For medication(s) to be administered or delivered by a provider or facility** |
| **MercyCare ID:**       | **Date of Birth:**       |

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| **Diagnosis:**       |
| **[ ]  New therapy** | **[ ]  Dose change** | **[ ]  Continuation of therapy** |
| **Duration:**  | **[ ]  3 months** **[ ]  6 months** **[ ]  1 year** **[ ]  Other:**       |
| **HCPCS Code** | **Drug Name** | **Dosage/Administration Frequency** | **Route** |
|       |       |       |       |
|       |       |       |       |
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| **Provider’s Notes / Explanation / Medication History:**       |
|       |
|       |
|       |
|       |
| **\*Please attach supporting medical records\*** |

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| **Provider Signature:**  | **Date:**       |
| **Provider Name:**       | **Department/Specialty:**       |
| **Phone:**       | **Fax:**       |
| **Facility Name:**       |
| **Address *(Street, City, State, Zip)*:**       |
| **Location of medication administration/delivery if different from requesting provider:** | **Provider/Facility Name:**       |
| **Address *(Street, City, State, Zip)*:**       |
| **Phone:**       | **Fax:**       |