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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:** | | | | | | |
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| **\*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:** | |