



Biopharmacy Medication Request Form
Sunflower Health Plan



This form is for **home health and office injections or infusions**.
For questions, call 877-644-4623.

Fax to: 888-453-4756

Or mail to: Sunflower Pharmacy Dept.
8325 Lenexa Drive, Suite 200
Lenexa KS, 66214

MEMBER INFORMATION		PRESCRIBER INFORMATION	
Medicaid ID #		Name	
First Name		Specialty	
Last Name		NPI #	
Date of Birth		Group or Hospital	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
		Phone	
		Fax	
		Contact Name	
MEDICATION SUPPLIER (choose from the options below)			
<input type="checkbox"/> Acaria Health [skip A-D] <input type="checkbox"/> Dispense from Office, Hospital, Outpatient Center Stock <input type="checkbox"/> Other			
A. Location Name			
B. Location NPI			
C. Phone			D. Contact Name
INSURANCE INFORMATION			
Primary Insurance:		Secondary Insurance:	
ID Number:		ID Number:	
Phone Number:		Phone Number:	
DIAGNOSIS			
Diagnosis Date:		ICD10:	
Diagnosis:	<i>NOTE: Include diagnostic clinicals (labs, radiology, etc.). For Chemotherapy Medication Requests, include Regimen and Anticipated Dates of Service</i>		
MEDICATION HISTORY			
A. Is the member currently treated with this medication?			
<input type="checkbox"/> YES; How long? _____ [go to item B] <input type="checkbox"/> NO [skip items B & C; go to item D]			
B. Is this request a continuation of a previous approval by Sunflower State Health Plan?			
<input type="checkbox"/> YES [go to item C] <input type="checkbox"/> NO [skip item C; go to item D]			
C. The strength, dosage, or quantity required per day has:			
<input type="checkbox"/> INCREASED [go to item D] <input type="checkbox"/> DECREASED [go to item D] <input type="checkbox"/> REMAINED THE SAME [go to item D]			
D. Indicate PREVIOUS medications treatment/outcomes below.			
Drug Name, Strength, and Dosage		Dates of Therapy	Reason for Discontinuation
1.			
2.			
3.			
MEDICATION REQUESTED (NOTE: You must list the package size NDC for claim or the request will be returned.)			
Medication Name/ NDC/JCODE		Dosage/Strength:	
Quantity:		Directions:	
Refills:		Start & End Date:	

Prescriber's Signature: _____ Date: _____

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