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)

☐ **Acaria Health** [skip A-D] ☐ **Dispense from Office, Hospital, Outpatient Center Stock** ☐ **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:		*NOTE: Include diagnostic clinicals (labs, radiology,etc.). For Chemotherapy Medication Requests, include Regimen and Anticipated Dates of Service*	

MEDICATION HISTORY

A. Is the member currently treated with this medication?
☐ YES; How long?_____ [go to item B] ☐ NO [skip items B & C; go to item D]

B. Is this request a continuation of a previous approval by Sunflower State Health Plan?
☐ YES [go to item C] ☐ NO [skip item C; go to item D]

C. The strength, dosage, or quantity required per day has:
☐ INCREASED [go to item D] ☐ DECREASED [go to item D] ☐ 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: _____