



StayWell
INSURANCE

Medication Request Form

Attn: Prior Authorization Department

10181 Scripps Gateway Court San Diego, CA 92131

Toll Free Phone: 1-800-788-2949

Toll-Free Fax: 855-236-4067

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Medication Request Information: Please complete each section of this form prior to transmittal to the toll-free fax number listed above.

***Denotes Required Fields**

PATIENT INFORMATION			PHYSICIAN INFORMATION	
*Name:			*Name:	
*ID#:			*Specialty:	
*Date of Birth:	*Height:	*Weight:	ID# / DEA#:	
*Health Plan:			*Phone: () -	*Fax: () -
*Diagnosis (ICD-10 Code, and Description required):				
REQUESTED DRUG INFORMATION			PHARMACY INFORMATION	
*Requested Drug:			Name:	
Dose:	Strength:		Phone: () -	Fax: () -
Quantity: (per month)	Dosage Form: (Oral, Injection, etc)		Length of Treatment: (Please be specific.)	
Reason for Medication Request (Please be specific, give detail and attach clinical notes):				
Other Medications Tried and/or Failed (Please be specific, give detail.):				
Other Pertinent History (Relative or pertaining to this request and attach pertinent medical reports):				

***Please Note: Receipt of this form does not guarantee approval for the above-mentioned medication. Any information left blank or ineligible may delay the review process.**

REQUEST FOR EXPEDITED (URGENT) REVIEW: BY CHECKING THIS BOX, I CERTIFY THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

DO NOT WRITE IN THIS AREA. FOR INTERNAL USE ONLY

PA# _____
Approved Denied Duration: _____
Returned on _____
Comments: _____

Date: ____/____/____