# 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

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**DO NOT WRITE IN THIS AREA. FOR INTERNAL USE ONLY**

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

_____

_____

**Date:** ____/____/_____