Medication Request Form

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

Attn: Prior Authorization Department
10181 Scripps Gateway Court
San Diego, CA 92131
Phone: 1-800-788-2949
Fax: 858-790-7100

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

Instructions:
This form is to be used by participating physicians and providers to obtain coverage for a formulary drug requiring prior authorization (PA), a non-formulary drug for which there is no suitable alternative available, or any overrides of pharmacy management procedures such as step therapy, quantity limit or other edits. Please complete this form and fax to MedImpact Healthcare Systems, Inc. at (858) 790-7100 or please call (800) 788-2949 with this information. If you have any questions regarding this process, please contact MedImpact's Customer Service at (800) 788-2949.

Review Criteria:
The following criteria are used in reviewing medication requests:
1. The use of Formulary Drug Products is contraindicated in the patient.
2. The patient has failed an appropriate trial of Formulary or related agents.
3. The choices available in the Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
4. The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care.

☐ **REQUESTFOREXPEDITED(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

Medication Request Information (please complete each section of this form prior to transmittal): *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, if known):				
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.):				
Other Medications Tried and/or Failed (Please be specific, give detail.):				
Other Pertinent History (Relative or pertaining to this request.):				

Revised: 10/18

Clear Print