



# Medication Request Form

Attn: Prior Authorization Department  
10680 Trenea Street, Suite 500  
San Diego, CA 92131  
Phone: 1-800-788-2949  
Fax: 1-800-681-7651



### Instructions:

This form is required by participating physicians and practitioners to obtain coverage for 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 System, Inc. at 1-858-790-7100.
- You can call in an expedited request at 1-800-788-2949 and fax the form to MedImpact by the next business day.
- If you have any questions regarding this process, please contact MedImpact's Customer Service at 1-800-788-2949.
- **Failure to fully complete and sign this form may result in an adverse determination.**

**Review Criteria:** Drugs requiring Prior Authorization will be reviewed according to criteria established by L.A. Care Health Plan. The following criteria are used in reviewing a non-formulary drug request:

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.

**Medication Request Information: Please complete all sections of this form by printing neatly prior to transmittal.**

<b>Patient Name (1)</b>	<b>Patient's Health Plan (2)</b>	
<b>Patient ID # (3)</b>	<b>Physician Name (4)</b>	<b>Specialty (5)</b>
<b>Patient DOB (6)</b>	<b>Physician NPI# (7)</b>	<b>DEA # (8)</b>
<b>Diagnosis (9)</b>	<b>Physician Telephone Number (10)</b> (     ) -     -	
	<b>Physician Fax Number (11)</b> (     ) -     -	
<b>Pharmacy used by Patient (12)</b>	<b>Pharmacy Telephone Number (13)</b> (     ) -     -	
<b>Drug Requested (14)</b>	<b>Quantity (per month) (15)</b>	
<b>Dose (16)</b>	<b>Length of Treatment (please be specific) (17)</b>	
<b>Strength (18)</b>	<b>Route (e.g. PO, SQ) (19)</b>	
<b>Reason for Medication Request (please be specific, give detail) (20)</b>		
<b>Other Medications Tried and/or Failed at therapeutic dose and duration (please provide specific details and attach signed progress notes and/or pharmacy history claims) (21)</b>		
<b>Prescriber Signature (required) (22)</b> _____		<b>Date (required) (23)</b> _____
<b>Submitted by (24)</b> _____	<b>Title (25)</b> _____	<b>Direct Phone Number (26)</b> (     ) _____