Adult Medical Nutrition Request Form

Attn: Prior Authorization Department
10680 Treena 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 1-800-681-7651.
- 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.

Patient Name (1)	**Patient's Health Plan** (2)
Patient ID # (3)	**Physician Name** (4) **Specialty** (5)
Patient DOB (6) ≥ 21 years old __ Y or __ N	**Physician NPI#** (7) **DEA #** (8)
Diagnosis (9) include ICD9 up to the 5th digit ○ Inborn Error of Metabolism ○ ICD9=____________ ○ Malabsoprtion ○ ICD9= ____________	**Physician Telephone Number** (10) ( ) - **Physician Fax Number** (11) ( ) -
Pharmacy used by Patient (12)	**Pharmacy Telephone Number** (13) ( ) -
Drug Requested (14)	**Quantity (per month)** (15)
Dose (16)	**Length of Treatment (please be specific)** (17)
Strength (18)	**Route** (19) __ Oral or __ Feeding Tube

Pertinent Information: (please be specific and attach to the request details of the below) (20)

- Patient diagnosis, related to the request for product coverage (mandatory)
- Patient age, height and weight (mandatory)
- Patient's other additional anthropometric (BMI), biochemical (Labs), clinical and/or dietary indicators
- Patient specific caloric requirement, for one day of product intake
- Caloric density of product requested (if available)

Prescriber Signature **(required)** (21) ______________________ Date **(required)** (22) __________

Submitted by (23) ______________ Title (24) ____________ Direct Phone Number (25) (_____)__________

Revised: 04/2012