

Medication Prior Authorization Request Form

Your request cannot be processed without complete information which includes provider specialty and address

Member Name:	Provider Name:
Member ID:	Address:
Address:	
	Phone:
Phone:	Fax :
Date of Birth:	Specialty:

Medication (drug & strength): _____	
Directions for use: _____	
Diagnosis: _____	
Date patient started medication (if previously used): _____	
Name of specific medication(s) tried and failed: _____	
Reason for non-formulary request, and/or clinical justification for requested drug use: <i>(Please include relevant lab values when appropriate. NOTE: Patient chart notes will be requested if further documentation is necessary.)</i> _____ _____ _____	
Requesting Prescriber/Provider Signature: _____	Date: _____
Additional Notes: _____ _____ _____	

To Prescriber- Complete ENTIRE form, SIGN and return to:

Prior Authorization Department
3515 Harbor Blvd.
Costa Mesa, CA 92626
Phone: 1-800-711-4555
Fax: 1-800-527-0531

Please call to expedite your request