Medication Request Form for Members
For Prior Authorizations and Exceptions Requests

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 you, the member, to obtain coverage for a formulary prescription 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 that will negatively impact the member's health.
2. The member has failed an appropriate trial of Formulary or related medications.
3. The choices available in the Drug Formulary are not suited for the present member care need and the drug selected is required for member safety.
4. The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to member care.

☐ **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 YOU 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 (Print Clearly*)	PHYSICIAN INFORMATION
*Name:	*Name:
*ID#:	*Phone: ( ) -
*Date of Birth:	*Specialty:
REQUESTED DRUG INFORMATION	**PHARMACY INFORMATION**
*Requested Drug:	Name:
Strength:	Phone: ( ) -

*Quantity Prescribed: (per month)	Dosage Form: (Oral, Injection, etc)	Length of Treatment: (Please be specific.)
*Directions (Example: 2 tablets twice a day):		
*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.):		