Medi-Cal Rx Prior Authorization Request Form

Instructions: Fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). **Information contained in this form is Protected Health Information under HIPAA.**

Beneficiary Information

Last Name: _____ **First Name:** _____

Date of Birth: _____ **Phone Number:** _____

Beneficiary ID Number: _____

Street Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

☐ **Male** ☐ **Female** **Height** (in/cm): _____ **Weight** (lb/kg): _____

Allergies: _____

Prescriber Information

Last Name: _____ **First Name:** _____

Prescriber NPI Number: _____ **Prescriber Specialty:** _____

Prescriber Phone Number: _____ **Prescriber Fax Number:** _____

Street Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Requestor Information *(if different than Prescriber)*

Requestor (Business Name or First/Last): _____

Requestor NPI Number: _____

Requestor Phone Number: _____ **Requestor Fax Number:** _____

Beneficiary Last Name: _____ **Beneficiary First Name:** _____

Medication / Medical and Dispensing Information

Medication Name: _____

Dose/Strength: _____ **Frequency:** _____

Length of Therapy/#Refills: _____ **Quantity:** _____

☐ New Therapy ☐ Renewal

If Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____

How did the patient receive the medication?

☐ Paid under Insurance Name: _____ Prior Auth # (if known): _____

☐ Other (explain): _____

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other: _____

Administration Location: ☐ Patient's Home ☐ Long Term Care

☐ Physician's Office ☐ Home Care Agency ☐ Outpatient Hospital Care

☐ Ambulatory Infusion Center ☐ Other (explain): _____

1. Has the patient tried any other medications for this condition?

☐ **Yes (if Yes, complete below)** ☐ **No**

Medication/Therapy #1 (Drug Name and Dosage): _____

Duration of Therapy (Specify Dates): _____

Response/Reason for Failure/Allergy: _____

_____

Medication/Therapy #2 (Drug Name and Dosage): _____

Duration of Therapy (Specify Dates): _____

Response/Reason for Failure/Allergy: _____

_____

Medication/Therapy #3 (Drug Name and Dosage): _____

Duration of Therapy (Specify Dates): _____

Response/Reason for Failure/Allergy: _____

_____

Beneficiary Last Name: _____ **Beneficiary First Name:** _____

2. List Diagnoses:	**ICD-10:**

3. Required Clinical Information – Provide relevant information to support a prior authorization.

Please provide symptoms, lab results with dates, and/or justification for initial or ongoing therapy or increased dose, and if patient has any contraindications for the preferred drug(s). Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that Medi-Cal Rx or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Provider Signature: _____ **Date:** _____

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Save time and, often, receive real-time determinations by submitting electronically through CoverMyMeds®. Please go to www.covermymeds.com for more information.

Fax this form to: 1-800-869-4325

Mail requests to: Medi-Cal Rx Customer Service Center
ATTN: PA Request
P.O. Box 730
Rancho Cordova, CA 95741-0730
Phone: 1-800-977-2273