Medi-Cal Rx Prior Authorization Request

Instructions: Fill out all applicable sections on every page completely and legibly. Attach any additional documentation that is important for the review, such as chart notes or lab data, to support the prior authorization (PA).

Failure to submit the requested information may result in a returned PA request.

Submit one PA request per member. If you need to submit PA requests for multiple members, you must submit one form per member.

This form contains Protected Health Information (PHI) that is protected under HIPAA.

Member Information

Last Name: _____ First Name: _____

Date of Birth: _____ Phone Number: _____

Member ID Number: _____

Member Address: _____

City: _____ State: _____ ZIP Code: _____

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

Allergies: _____

Prescriber Information

Last Name: _____ First Name: _____

Prescriber National Provider Identifier (NPI) Number: _____

Prescriber Specialty: _____

Prescriber Phone Number: _____ Prescriber Fax Number: _____

Prescriber 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: _____

Requestor Address: _____

City: _____ State: _____ ZIP Code: _____

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

Medication/Medical and Dispensing Information

Medication Name: _____

Is this request for a drug with a dispense as written (DAW) code of DAW 1? ◯ Yes ◯ No

Strength: _____ Formulation: _____

Directions for Use: _____

Length of Therapy/Number of Refills: _____ Quantity: _____

◯ New Therapy ◯ Renewal ◯ Appeal request for a PA denied in the past 180 days

If Renewal:

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

How did the patient receive the medication?

◯ Paid Under Insurance

Insurance Name: _____

PA Number (if known): _____

◯ Other: _____

Administration:

◯ Oral/Sublingual (SL) ◯ Topical ◯ Injection ◯ Intravenous (I.V.)

◯ Other: _____

Administration Location:

◯ Patient's Home ◯ Long Term Care ◯ Physician's Office ◯ Home Care Agency

◯ Outpatient Hospital Care ◯ Ambulatory Infusion Center

◯ Other (explain): _____

1. Product Use History

Has the patient tried any other medications for this condition? ◯ No ◯ Yes

If **Yes**, complete the following fields:

Medication/Therapy 1

Drug Name and Dosage: _____

Duration of Therapy (Specific Dates): _____

Response/Reason for Failure/Allergy:

_____

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

Medication/Therapy 2

Drug Name and Dosage: _____

Duration of Therapy (Specific Dates): _____

Response/Reason for Failure/Allergy:

_____

Medication/Therapy 3

Drug Name and Dosage: _____

Duration of Therapy (Specific Dates): _____

Response/Reason for Failure/Allergy:

_____

2. Diagnosis and ICD-10

List the diagnoses and the associated ICD-10:

Diagnosis	ICD-10

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

3. Required Clinical Information

Provide any additional clinical information or supporting medical documentation to support a PA, such as 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. 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.

Note: If the request is for an off-label use of the medication or if it exceeds dosage limits approved by the U.S. Food and Drug Administration (FDA), submit article(s) from major peer-reviewed medical journals that present data supporting that the proposed off-label use is safe and effective for the patient's age and diagnosis.

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: _____

Confidentiality Notice

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Save time and, often, receive real-time determinations by submitting electronically through CoverMyMeds®. Go to www.covermymeds.health 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