MEDICAL ASSOCIATES HEALTH PLANS

Phone: (563) 584-3275 (800)-325-7442
Fax: (563) 584-4893
**** Please send supporting clinical along with completed form****

Patient Name: _____ **Member #** _____

Drug Requested: _____ **Dosage:** _____

Physician Name: _____ **Department:** _____

Physician Phone: _____ **Fax:** _____

Pharmacy Name: _____ **Phone:** _____

Diagnosis: _____

YES NO (Indicate all that apply):

___ ___ Member entering MAHP from another health plan currently established on medication.

___ ___ Member started on medication during recent inpatient hospitalization.
If yes, please list hospitalization and discharge date._____

___ ___ Other considerations: (Other medications tried, Allergic reactions, Side effects etc).
Please document: _____
_____
_____

___ ___ Drug interactions precluding the use of formulary medication or step therapy. If yes, list Interacting drugs: _____

___ ___ If request is for a Non-Formulary medication, or to bypass step therapy, or for any other reason, please list: _____
_____
_____

____ ____ Member has met step therapy.

Request: Approved PA # _____ # of Fills_____ Redirected Denied

If denied or redirected please give reason: _____
_____
_____

Approved By: _____ Date: _____