2023
10181 Scripps Gateway Court
San Diego, CA 92131

Fax: (858) 790-7100

Prior Authorization Request Form

THIS FORM IS TO BE USED BY PRESCRIBERS ONLY and REQUIRES PRESCRIBER SIGNATURE

This form is being used for:

Check all that apply: ☐ Initial Request ☐ Continuation of Therapy/Renewal Request ☐ Request for Compound
☐ Other (please specify): _____

Patient Information:

Patient Name:	DOB:	Phone #:	
Address:	City:	State:	Zip:
Member ID#:	Plan Name:		
Requestor's Name & relationship to enrollee (if not patient or prescriber):			

Prescriber Information:

Prescribing Clinician:		Office Phone #:	
Specialty:		Office Secure Fax #:	
NPI #:		DEA:	
Address:	City:	State:	Zip:

Medication Information

Requested Medication:	
Strength:	Dosage Form:
Quantity:	Day supply:
Directions:	
Diagnosis(es) related to request:	
ICD-10 Code(s):	

Quantity Limit Requests

Please select all that apply:
- ☐ Request for titration (Provide titration schedule below)
- ☐ Tried and failed plan's quantity limit (Provide rationale below)
- ☐ Unable to dose consolidate (Provide rationale below)
- ☐ Requested strength/dose not commercially available
- ☐ Request is for insulin (Provide TOTAL daily units below)
- ☐ Other (please specify):

Brand Request (DAW): ☐ Yes ☐ No
If Yes, has the patient had an allergic reaction (e.g., hives/urticaria, rash, anaphylaxis) to at least 1 generic manufacturer? ☐ Yes ☐ No
If Yes, has the patient had a non-allergic reaction, therapeutic failure, or side effect with at least 2 generic manufacturers (if available) of the requested drug? ☐ Yes ☐ No
If Yes, has a MedWatch form been submitted documenting the therapeutic failure or adverse outcome experienced? ☐ Yes ☐ No

Clinical Information and History

Drug Name	Strength	Dates of Use	Description of Adverse Reaction or Tried and Failed

Supporting information such as: lab values, contraindications, allergies, or any other information relevant to this request.
Drug Allergies: **Height:** **Weight:**
Other:

☐ **Urgent (Complete this section ONLY if URGENT):**
By signing below, you are attesting that waiting for a standard decision could seriously harm the patient's life, health, or ability to regain maximum function.

_____ _____
PRESCRIBER SIGNATURE REQUIRED **Date:**
The Prescriber confirms the above information is accurate and can be verified by patient records.

☐ **Non-Urgent (Complete this section ONLY if NON-URGENT):**

_____ _____
PRESCRIBER SIGNATURE REQUIRED **Date:**
The Prescriber confirms the above information is accurate and can be verified by patient records.