DRUG PRIOR AUTHORIZATION REQUEST

CONFIDENTIAL PATIENT INFORMATION

San Diego CMS Program

Fax to: 866-511-2202

Customer Service Help Desk: (800) 777-0074

If this is an URGENT REQUEST check here: ☐

Fax to the 'Urgent Fax Line' at 877-636-9001. **Note: This line MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. NMHC Clinical Pharmacists reserve judgment of urgency and must meet definition above, therefore, please explain reason for urgency below. This fax line monitored for abuse.**

Top portion and medication request information to be completed by physician requesting prior authorization.

Name of Member's Health Plan:

Member's Program: CMS RW CI (circle one)

Date of Request: Physician:

MD office Contact Person: Signature:

Physician's Fax Number: Physician's Phone Number:

Physician's Specialty:

Pharmacy Name: Pharmacy Fax Number: ( )

Pharmacy Contact: Pharmacy Phone Number: ( )

Patient's Last Name, First Name	Patient's ID# or SSN#
Sex: Male Female	Patient's DOB
Patient's Phone Number	

MEDICATION REQUEST ☐ NEW ☐ RENEWAL---RENEWAL ORIGINAL RX DATE:_____

DIAGNOSIS (LIST RELEVANT):

CURRENT MEDICATION(S):

FORMULARY DRUGS TRIED AND MEDICAL JUSTIFICATION:

DRUG AND STRENGTH: _____ NDC: _____

DIRECTIONS: _____ MONTHLY QTY: _____ #REFILLS: _____

FOR Informed Rx USE ONLY

Approved ___ Denied ___ Deferred for Additional Information ___ Approved As Modified ___ Pt. Not Eligible ___

COMMENTS: _____

Authorizing Signature _____ Date _____

NDC VALID: EXPIRES: _____