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.

Information on this form is Protected Health Information and subject to all privacy and security regulations under HIPAA