



CONTAINS CONFIDENTIAL PATIENT INFORMATION

Submit requests to the Prior Authorization Center at:

	Fax	Call
Medi-Cal / CalWrap	858-357-2557	888-807-5705
OneCare HMO SNP (Medicare Part D)	858-357-2556	800-819-5532
OneCare Connect (Medicare-Medicaid)	858-357-2556	800-819-5480

Request Type <input type="checkbox"/> New <input type="checkbox"/> Renewal <input type="checkbox"/> Retroactive <input type="checkbox"/> Appeal	Request is for a hospital discharge medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Patient CalOptima ID #: _____	Prescriber Phone #: _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female DOB: _____	Prescriber Fax #: _____
Other Primary Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Prescriber Specialty: _____
Name of Primary Insurance: _____	Prescriber NPI #: _____
	Prescriber Signature: _____

For Medicare Part D, an enrollee, an enrollee's representative, or an enrollee's prescribing physician or other prescriber may request a coverage determination

PATIENT LOCATION INFORMATION	PHARMACY INFORMATION
Patient Location: <input type="checkbox"/> Home <input type="checkbox"/> B&C <input type="checkbox"/> Sub-Acute <input type="checkbox"/> SNF <input type="checkbox"/> ICF	Pharmacy Name: _____
Name of Facility: _____	Pharmacy NPI #: _____
Facility Phone #: _____	Pharmacy Phone #: _____
	Pharmacy Fax #: _____

Urgent*
 *The prescriber attests that applying the standard turn-around time could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request. Post service requests are not urgent.

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY
Drug Name: _____			
NDC#: _____			

REVIEW CRITERIA:
 What is the diagnosis? _____ **OR** ICD-10 code: _____
 New Therapy? Yes No # Refills? _____

Medical Justification Supporting Statement (include formulary drugs that have been tried, why the requested drug is medically required, and why formulary drugs would not be appropriate). If applicable, include dates and reason for retroactive authorization requests.

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The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.
 Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Confidential information
 Fax is intended only for the individual to whom it is addressed.
 If you are not the intended, do not read, copy, or distribute this information. Thank You.