

Network Health Prior Authorization Request

Medication Request Form (MRF)

FAX TO: (858) 790-7100 or (877) 501-1059

c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department

10680 Treena Street, Suite 500, San Diego, CA 92131 - Phone: 1-800-788-2949

Instructions:

This form is to be used by participating providers to obtain coverage for the drugs listed above, which require prior authorization. Please complete this form and fax it to MedImpact Healthcare Systems, Inc. at (877) 501-1059. If you have any questions regarding this process, please contact MedImpact's Customer Service at (800) 788-2949.

Review Criteria:

The following criteria are used in reviewing medication requests:

1. The use of Formulary Drug Products is contraindicated in the patient.
2. The patient has failed an appropriate trial of Formulary or related agents.
3. The choices available in the Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
4. The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care.

***** ONLY COMPLETED FORMS CAN BE PROCESSED *****

Member/Provider Information:

Member's Name:	Prescriber's Name:
Member's Network Health ID #:	Prescriber's Specialty:
Member's DOB (mm-dd-yy):	DEA # (Required): _____ NPI #: _____
Pharmacy used by Member:	Prescriber's Telephone Number / Contact Name:
Pharmacy (Area Code) Telephone Number:	Prescriber's (Area Code) Fax Number:

Clinical Information:

No Substitution - Brand Name Medically Necessary <input type="checkbox"/>	Diagnosis	
Requested Drug:		
Dose:	Strength:	Quantity: (per month)
Dosage Form: (Oral, Injection, etc.)	Length of Treatment: (Please be specific.)	
Reason for Medication Request (Please be specific, give detail.):		
Other Medications Tried and/or Failed (Please be specific, give detail.):		
Other Pertinent History (Relative or pertaining to this request.):		

Request for expedited review (72 hours): By checking this box, I certify that applying the standard review time frame may seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

SIGNATURE: I CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

Prescriber's Signature (STAMP NOT ACCEPTED)

Date