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: | | |

## 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.