



200 Oceangate Suite 100, Long Beach, CA 90802  
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## MEDICATION PRIOR AUTHORIZATION REQUEST FORM

<b>PRODUCT:</b> <input type="checkbox"/> <b>MEDI-CAL</b> <input type="checkbox"/> <b>HEALTHY FAMILIES</b> <input type="checkbox"/> <b>AIM</b>		
Service is: <input type="checkbox"/> <b>NON-URGENT</b> <input type="checkbox"/> <b>URGENT</b>		Date:                      /                      /
<small><b>ABUSE OF URGENT PA STATUS WILL BE MONITORED.</b> Urgent request 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. MHC reserve judgment of urgency and must meet definition above, therefore, please explain reason for urgency below.)</small>		
Member Name (Last, First, Middle Initial)	Date of Birth /                      /	Member I.D. -                      -
<b>PROVIDER INFORMATION</b>		<b>PHARMACY INFORMATION</b>
Provider name (last, first) & Specialty		Pharmacy Name
Provider's NPI and/or DEA#		
Phone Number (        )                      -		Phone Number (        )                      -
Fax Number (        )                      -		Fax Number (        )                      -
<b>PRIOR AUTHORIZATION REQUEST INFORMATION</b>		
New Request _____      Renewal _____      Renewal Original Rx Date _____		
Relevant Diagnosis (Include ICD-9 Code if available):  		
Drug Name, Strength, Monthly Qty, & Directions (Limited to one medication per form)		Expected Duration of Therapy/ # of Refills
<b>Medical Justification For Request</b> <small>- Include previous therapy/formulary agents tried and reasons for treatment failure, and attach all relevant medical records and test results, etc.          - Use of pharmaceutical samples cannot be accepted as medical justification.</small>		
To the best of my knowledge, the following information is true, accurate, and complete and the requested services are medically indicated and necessary for the health of the patient.		
<b>Requesting Practitioner Signature:</b>		<b>Date:</b> /                      /

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**CLAIMS PAYMENT IS CONTINGENT ON MEMBER ELIGIBILITY FOR DATE(S) OF SERVICE**