

Prior Authorization / Formulary Exception Request Fax Form

CoverMyMeds is Health Net's preferred way to receive prior authorization requests. Visit go.covermymeds.com/EnvolveRx to begin using this free service OR FAX this completed form to (800) 977-8226.

Form must be fully completed to avoid a processing delay.			quest, call: (800) 867-6564
Patient's Name (Last, First, MI)		Date of Birth MM / DD / YYYY	
		/	
Member ID # Please print clearly and enter one digit per box	Patient's Phone	Please print clearly and e	enter one digit per box
)	-
Patient's Address, City, State, Zip		Gender M F	Allergies
Provider's Name (Last, First, MI)		Provider Specialty	Contact Name
Provider's Address, City, State, Zip NPI #			
Provider's Phone Please print clearly and enter one digit per box	Provider's F	ax Please print clearly an	d enter one digit per box
			-
Medication Name and Strength	Quantity	Direction for Use and Dura	ation
Administered: Doctor's Office Dialysis Center Home Health By Patient Other (specify):			
Diagnosis	ICD Code	New Start with This Medic	ation: Yes No
		If No, Date of First Dose	
Medications Previously Tried with Dates of Use			
Medical Justification and Supporting Information (attach labs and/or chart notes as appropriate)			
For Commercial members for injectable drugs only:			
Are you the patient's primary care physician? Yes No Has the patient provided an authorized referral? Yes No No			
Utilization Management Authorization # (attach copy): The patient will obtain the medication from: The Provider A Pharmacy			vider
For Medicare members only: Please review carefully and complete each applicable subsection.			
For all requests: Is the patient currently receiving dialysis? Yes No			
For drugs considered to be High Risk Medications (HRM) for the elderly (i.e. drugs on Yes Comment: the Beers List), is the patient continuing on this medication without adverse effects? No			
For immunosuppressive medication requests: Is it being used for a transplant? Yes \(\Boxed{\text{No}} \) No \(\Boxed{\text{If Yes, Date of transplant:}}			
For antiemetic medication requests: Will this drug be used as full therapeutic replacement for intravenous antiemetic drugs within 2 hours and continued for a period not to exceed 48 hours of chemotherapy? Yes No			
For nutritional supplement (enteral or parenteral) medication requests: Does the patient have a G-tube? Yes No Does the patient have a permanent dysfunction of the digestive track? Yes No			
I certify that the above information is correct to the best of my knowledge.			
Physician's Signature Date			
Name of provider/vendor submitting this form if other than the prescriber above	F	Phone #	
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Mailing Address: Health Net Prior Authorization Department, P.O Box 419069, Rancho Cordova, CA 95741			
For copies of prior authorization forms and guidelines, please call (800) 867-6564 or visit the provider portal at www.healthnet.com.			