Prior Authorization / Formulary Exception Request Fax Form

FAX TO: (800) 977-8226

Form must be fully completed to avoid a processing delay.

For status of a request, 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 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 Fax ------- Please print clearly and enter one digit per box --------
( ) –	( ) –

Medication Name and Strength	Quantity	Direction for Use and Duration

Administered: ☐ Doctor's Office ☐ Dialysis Center ☐ Home Health ☐ By Patient ☐ Other (specify):

Diagnosis	ICD Code	New Start with This Medication: ☐ 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 ☐
Utilization Management Authorization # (attach copy):	The patient will obtain the medication from: The Provider ☐ A Pharmacy ☐

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 the Beers List), is the patient continuing on this medication without adverse effects?	Yes ☐ No ☐ Comment:
For **immunosuppressive** medication requests: Is it being used for a transplant? Yes ☐ No ☐	If Yes, Date of transplant:
For **antiemetic** medication requests: Will the patient be on any other concurrent antiemetic therapy? Yes ☐ No ☐ Specify drug(s) & route: _____	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? Does the patient have a permanent dysfunction of the digestive track?	Yes ☐ No ☐ 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	Phone #

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Mailing Address: HNPS Prior Authorization Department, 10540 White Rock Road #280, Rancho Cordova, CA 95670

For copies of prior authorization forms and guidelines, please call (800) 867-6564 or visit the provider portal at www.healthnet.com.

Revised 08-2015