

## CONTAINS CONFIDENTIAL PATIENT INFORMATION

Submit requests to the MedImpact Prior Authorization Center at:

Plan	Fax	Appeal Fax	Phone
OneCare HMO SNP (Medicare Part D)	858-357-2556	858-357-2588	800-819-5532

<b>What is the urgency?</b> <input type="checkbox"/> Standard <input type="checkbox"/> Urgent* <input type="checkbox"/> Retroactive	<b>Request is for a hospital discharge medication?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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\* The prescriber attests that applying the standard turnaround time could seriously jeopardize the life, health or safety of the member or others due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____ Patient CalOptima Health ID #: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female      DOB: _____ Other Primary Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Name of Primary Insurance: _____	Prescriber Name: _____ Prescriber Phone #: _____ Prescriber Fax #: _____ Prescriber Specialty: _____ Prescriber NPI #: _____ Prescriber Signature: _____

*For Medicare Part D, an enrollee, an enrollee's representative, or an enrollee's prescribing physician or other prescriber may request a coverage determination*

PATIENT LOCATION INFORMATION	PHARMACY INFORMATION
Patient Location: <input type="checkbox"/> Home <input type="checkbox"/> B&C <input type="checkbox"/> Sub-Acute <input type="checkbox"/> SNF <input type="checkbox"/> ICF Name of Facility: _____ Facility Phone #: _____	Pharmacy Name: _____ Pharmacy NPI #: _____ Pharmacy Phone #: _____ Pharmacy Fax #: _____

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY
Drug Name: _____ NDC#: _____			

**REVIEW CRITERIA:**

What is the diagnosis? _____ <b>OR</b> ICD-10 code: _____ New Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No      # Refills? _____      Date of Rx: _____
<b>Medical Justification Supporting Statement</b> <i>(include formulary drugs that have been tried, why the requested drug is medically required, why formulary drugs would not be appropriate and applicable labs):</i>  <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
If applicable, include dates and reason for retroactive authorization requests.
<i>The submitting provider certifies that the information provided is true, accurate and complete, and the requested services are medically indicated and necessary to the health of the patient.</i>
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

**Confidential information**

Fax is intended only for the individual to whom it is addressed.  
If you are not the intended, do not read, copy, or distribute this information. Thank You.