

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 | 855-584-8672 |

| | |
|--|--|
| What is the urgency? <input type="checkbox"/> Standard <input type="checkbox"/> Urgent* <input type="checkbox"/> Retroactive | Request is for a hospital discharge medication? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

* 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? _____ OR ICD-10 code: _____ New Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No # Refills? _____ Date of Rx: _____ |
|---|

Medical Justification Supporting Statement *(include formulary drugs that have been tried, why the requested drug is medically required, why formulary drugs would not be appropriate and applicable labs):*

If applicable, include dates and reason for retroactive authorization requests.

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.

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.