Medication Request Form

FAX TO: (888) 807-6643

c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department

10181 Scripps Gateway Court, San Diego, CA 92131 - Phone: 1-800-788-2949

Instructions:

Please complete this form and fax it to **MedImpact** Healthcare Systems, Inc. at (888) 807-6643. If you have any questions regarding this process, please contact **MedImpact's** Customer Service at (800) 788-2949. Questions about the clinical criteria used to make this determination may be discussed by contacting the Clinical Pharmacy Services Department at (888) 888-4742, extension 31786.

This form is being used for:		
Check one:	☐ Initial Request	☐ Continuation/Renewal Request
Reason for request *(check all that apply)*:	☐ Prior Authorization, Step Therapy, Formulary Exception ☐ Quantity Exception ☐ Specialty Drug ☐ Other *(please specify)*: ______	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)	

A. Patient Information		
Patient Name:	DOB:	Member ID #:

B. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
Prescribing Clinician or Authorized Representative Signature:	
Date:	

C. Medication Information	
Medication Being Requested:	
Strength:	Quantity:
Dosing Schedule:	Length of Therapy:
Date Therapy Initiated:	
Is the patient currently being treated with the drug requested? ☐ Yes ☐ No If yes, date started:	
If Relevant to This Request:	
Dispense as Written (DAW) Specified? ☐Yes ☐No	
Rationale for DAW:	
If the request is for an injectable medication, will it be self-administered? ☐ Yes ☐ No	
Pertinent Concurrent Medications:	

D. Renewal Requests
Has the patient experienced improvement while on therapy? ☐ Yes ☐ No
If yes, please describe:

CONTINUED ON NEXT PAGE – BOTH PAGES MUST BE COMPLETED IN ORDER TO BE PROCESSED

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E. Patient Clinical Information
***Please refer to plan-specific criteria for details related to required information. PA criteria can be found at https://www.harvardpilgrim.org/**
Primary Diagnosis Related to Medication Request:
ICD Codes:
Pertinent Comorbidities:
If Relevant to This Request:
For quantity limit exception requests, provide rationale for higher quantity:

F. Previous Therapies		
Drug Name and Strength	Last Fill Date	Details
Are there contraindications to alternative therapies? ☐ Yes ☐ No		
If yes, please list details:		
Were nonpharmacologic therapies tried? ☐ Yes ☐ No		
If yes, provide details:		

G. Relevant Lab Values (Documentation required)			
Lab Name and Lab Value	Date Performed	Lab Name and Lab Value	Date Performed

H. Compound and Off Label Use
Is Medication a Compound? ☐ Yes ☐ No
If Medication is a Compound, list ingredients:
For Compound or Off Label Use, include citation to peer reviewed literature:

I. Additional information pertinent to this request: