Medication Request Form (MRF)

c/o MedImpact Healthcare Systems, Inc.

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Attn: Prior Authorization Department

10680 Treena Street, Suite 500
San Diego, CA 92131
Phone: 1-800-347-5841
Fax: 1-877-606-0728

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

Instructions:

This form is to be used by participating physicians and providers to obtain coverage for a Prior Authorization drug for which there is no suitable alternative available. Please complete this form and fax to Med**Impact** Healthcare Systems, Inc. at (877) 606-0728 or please call (800) 347-5841 with this information. If you have any questions regarding this process, please contact Med**Impact** at (800) 347-5841. If the form is NOT correctly or legibly completed, the authorization review **will be delayed.**

Review Criteria:

Drugs requiring Prior Authorization will be reviewed according to criteria established by PEEHIP. The following criteria are used in reviewing a drug request:

1. The use of Formulary Drug Products is contraindicated in the patient.
2. The patient has failed an appropriate trial of Formulary or related agents.
3. The choices available in the Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
4. The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Name **(required):**	Patient Insurance Company and Contract Number **(required):**
Patient DOB **(required):**	Diagnosis **(required):**
Physician Name/Specialty:	Physician Area Code and Telephone Number: ( ) -
Physician DEA #:	Physician Area Code and Fax Number (required): ( ) -
Pharmacy used by Patient:	Pharmacy Area Code and Telephone Number: ( ) -
Drug Requested:	Quantity (per month):
Dose:	Length of Treatment **(please be specific)**:
Strength:	Dosage Form (e.g., Oral, Injection):
Reason for Medication Request (**please be specific, give detail**):	
Other Medications Tried and/or Failed (**please be specific, give detail**):	
Other Pertinent History (relative or pertaining to this request):	