Health Alliance Plan
Medicare Part D
Medication Request Form (MRF)
(Standard Form)

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

Attn: Prior Authorization Department

10680 Treena St., Suite 500
San Diego, CA 92131
Phone: 800-788-2949 Fax: 858-790-7100

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 drugs requiring prior approval/ medical exceptions. Please complete this form and fax to Med**Impact** Healthcare Systems.,Inc. 858-790-7100. If you have any questions regarding this process, please contact Med**Impa**ct's Customer Service at 800-788-2949.

An urgent request is one where applying the standard timeframe for response (72-hour) could seriously jeopardize patient life health or ability to recover. **For URGENT Request (24-hour review) give details**

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

Patient Name **(required)**:	Patient's Health Plan **(required)**:
Patient ID # **(required)**:	Physician Name:
	Physician Specialty:
Patient DOB **(required)**:	Physician Area Code and Telephone Number: ( ) -
Patient Area Code and Telephone # **(required)**: ( )	Physician Area Code and Fax Number **(required)**: ( ) -
Pharmacy used by Member:	Pharmacy Area Code and Telephone Number: ( ) -
Drug Requested:	Quantity (per month):
Strength:	Length of Treatment (**please be specific**):
Dose:	Dosage Form (e.g., Oral, Injection)

Other Pertinent History. **(As per CMS guidelines, for formulary exceptions require a physician's supporting statement. Please Provide details why the formulary drug is inappropriate is required).** Include drug(s) name, dose, and duration of use, side effect(s) and underlying medical reasons for requesting a formulary exception.

Request submitted by (Name and Position): Date: