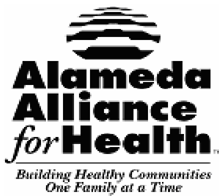

Alameda Alliance for Health
Medication Request Form

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Approved as Modified:
Deferred for Additional Info:
Denied:

Attn: Prior Authorization Department

10680 Treena Street, Suite 500
San Diego, CA 92131
Phone: 1-800-788-2949 (24hrs/7days)
Fax: 858-790-7100

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Reviewer:
Signature:
Date:
PA #:

☐ **Urgent Request** (Must be reserved for requests that, in the provider's best professional judgment, are potentially life threatening or pose a significant risk to the continuous care of the patient.)

Instructions:
This form is to be used by participating physicians and providers to obtain coverage for a non-formulary drug for which there is no suitable alternative available. Please complete this form and fax to **MedImpact** Healthcare Systems, Inc. at (858) 790-7100 or please call (800) 788-2949 with this information. If you have any questions regarding this process, please contact **MedImpact's** Customer Service at (800) 788-2949.

Review Criteria:
The following criteria are used in reviewing medication requests:
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. Samples will not be considered as justification for medical necessity.
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's Health Plan (required): Alameda Alliance for Health
Patient ID # (required):	Physician Name/Specialty:
Patient DOB (required):	Physician ID#/DEA #::
Diagnosis (required):	Physician Area Code and Telephone Number (required): ( ) -
Pharmacy used by Member:	Physician Area Code and Fax Number (required): ( ) -
Pharmacy Area Code and Telephone Number: ( ) -	Physician's Signature:
Pharmacy Area Code and Fax Number (required): ( ) -	Date of Request:
NOTE: Self injectables will be dispensed by a Specialty Pharmacy via mail.	
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):	