Los Angeles County Department of Mental Health
Office of the Medical Director

Pharmacy Services
550 South Vermont Avenue
Los Angeles, CA 90020

Fax to Magellan Pharmacy Solutions: (800) 424-7385
Phone: (800) 424-6811

Medication Treatment Authorization Request (M-TAR)

Client Information	First Name, Last Name:	Clt. ID #:	Date of Birth (MM/DD/YYYY):	Gender:	Date Requested:*
	Requested Medication and Strength:				☐ Initial ☐ Continued
	Primary Diagnosis/Relevant Medical Condition(s)/Substance Use Disorder(s)				

Medication-Specific Criteria (Note: Check boxes under specific medication to attest that ***all*** criteria is met for that medication)

Psychostimulants

☐ Client is over the age of 16 and has been prescribed psychostimulants by a DMH prescriber (directly-operated or contracted site) continuously for at least one year prior to the request.

Anticraving medications (Acamprosate, Naltrexone ER, Varenicline, Buprenorphine)

☐ Client has substance use disorder with significant impairment.
☐ Client is receiving ongoing substance abuse counseling.
☐ Clinical record documents evidence of effectiveness after 3 months use.

Zolpidem (and other off-formulary insomnia medications)

☐ Client is not currently prescribed or receiving benzodiazepine.
☐ Client does not have current substance use diagnosis.
☐ If client is currently using requested medication, length of time from first prescription is less than six months.

Branded Antipsychotic Polypharmacy (Please note current and past medications in Rationale Section)

☐ Client/Medication not eligible for Indigent Medications Program.
☐ Monotherapy or alternative polypharmacy (use of more than 1 branded antipsychotic) would cause significant adverse effects and/or poor outcomes.
☐ Client had an unfavorable response to the current medication that requires an immediate switch.

Please indicate one:

☐ Switch
☐ Ongoing Polypharmacy
☐ Transfer of Care (e.g. hospital discharge)

Rationale (For any medication listed above, include additional information related to request.)
(For any medication not listed above, describe complete clinical rationale for request and attach additional documentation if necessary)

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Prescriber/Furnisher Information (***I hereby state that all of the indicated conditions pertain and the documented reasons for these conditions are accurate.***)

Name:	Signature:	Supervising Psychiatrist Name:**	Signature:
DMH Site/Clinic Name:	Phone #:	**FAX # (REQUIRED):**	

* M-TARs received on Friday after 12 p.m. will be reviewed on the next business day.
**Designees must include name of Supervising Psychiatrist and Designee name and signature. No Supervising Psychiatrist signature is required if the site is a DMH contracted provider.

This confidential information is provided to you in accord with State Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled. This facsimile and any attached documents are confidential and are intended for the use of individual or entity to which it is addressed. If you received this in error, please notify us by telephone immediately at (213) 738-4725.