PRECRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: My Health LA **Plan/Medical Group Phone#:** (213) 288-8476
Plan/Medical Group Fax#: (310) 669-5609 **Plan/Medical Group Email:** PRIORAUTH@DHS.LACOUNTY.GOV

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g., chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance					
First Name:	Last Name:		MI:	Phone Number:	
Address:	City:		CA	Zip Code:	
Date of Birth:	[ ] Male [ ] Female	Height :	Weight:	Allergies:	
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:			

Insurance/Coverage Information	
Primary Insurance/Coverage Name: **My Health LA**	MHLA Patient ID Number:
Secondary Insurance Name: N/A	Patient ID Number: N/A

Prescriber Information			
First Name:	Last Name:	Specialty:	
Address:	City:	CA	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information			
Medication Name:			
[ ] New Therapy [ ] Renewal If Renewal: Date Therapy Initiated:		Duration of Therapy (specific dates):	
How did the patient receive the medication? [ ] Paid under Insurance Name:_____ Prior Auth Number (if known):_____ [ ] Other (explain):			
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:
Administration: [ ] Oral/SL [ ] Topical [ ] Injection [ ] IV [ ] Other:			
Administration Location: [ ] Physician's Office [ ] Ambulatory Infusion Center	[ ] Patient's Home [ ] Home Care Agency [ ] Outpatient Hospital Care	[ ] Long Term Care [ ] Other (explain): _____	

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	MHLA Patient ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? [ ] **YES (if yes, complete below)** [ ] **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-9/ICD-10:**

3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

[X] Attachments PLEASE ATTACH RELEVANT PROGRESS NOTE, LABS, CURRENT MEDS, and CLINICAL RATIONALE

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date**: _____

Plan Use Only: Date of Decision:_____

☐ Approved ☐ Denied Comments/Information Requested: _____

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