



PRESCRIPTION DRUG PRIOR AUTHORIZATION (PA) REQUEST FORM

LACDMH CARE Fund Phone: (844) 571-2987

LACDMH Drug Formulary: <https://dmh.lacounty.gov/for-providers/clinical-tools/pharmacy-services>

Client Information				
LAST Name: *	FIRST Name: *	MI:	Date of Birth: *	Sex: * ☐ Female ☐ Male ☐ Unspecified
Member ID / DMH MRN / IBHIS #: *	Allergies: *	Pharmacy Info:		
Prescriber Information				
LAST Name: *	FIRST Name: *	NPI Number (individual): *	DEA Number (if applicable):	
DMH Site / Clinic Name: *	Phone Number: *	Fax Number (in HIPAA compliant area): *		
Medication Information				
Medication Name / Strength: *	SIG: *	Quantity: *	Days Supply: *	Route of Administration: * ☐ PO ☐ SL ☐ IM ☐ SC ☐ Other
Is client CURRENTLY being treated with this medication? * ☐ Yes ☐ No	Date medication was initiated (if applicable):	How did client previously receive this medication? (if applicable) ☐ Paid under insurance name: _____ ☐ Samples		
1a. Diagnoses (including ICD-10):			1b. Symptoms:	
Primary Diagnosis: *				
Additional Diagnoses:				
2. Has client tried FORMULARY medications for this condition? * (if YES, complete section)			☐ YES ☐ NO	
Medication Name	Strength/Dose	Duration of Therapy (MM/YYYY – MM/YYYY)	Response / Reason for Failure / Intolerability	
3. Is there documented history of successful therapeutic control with requested medication? * ☐ YES ☐ NO (If YES, provide date of medication initiation, assessment of interim adherence, and recent assessment of clinical response)				
4. Please PROVIDE JUSTIFICATION for why formulary medications are not adequate for client. Please also provide any additional clinical information or comments pertinent to this request for coverage, including extenuating circumstances, etc. *				
5. ATTACH DOCUMENTATION (i.e., chart notes, medication administration/dispense history, lab results, etc.) to support answers to questions 1-4 above. *				

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the payor 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/Furnisher's Signature: _____ **Date:** _____

(Prior Authorizations received on Friday after 12:00 p.m. PST will be reviewed the next business day)

* Required

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