Pharmacy Prior Authorization Form – Medical Necessity

Fax Completed Form to (818) 676-8086

PA forms and guidelines are available on the provider portal of www.healthnet.com

If the fax number provided is not a dedicated machine to you or your staff, please check this box ☐

Patient Name	Date of Birth
Patient's ID Number	Address, City, Zip Code

Physician's Name and Specialty	Medical Group Name
Physician's Address	City, State, Zip Code
Physician's Phone Number ( )	Physician's Fax Number ( )
Are you the patient's primary care physician? ☐ YES ☐ NO	Has the patient provided an authorized referral? ☐ YES ☐ NO
Utilization Management Authorization # (attach copy)	Is this request from the MAIL ORDER PHARMACY? ☐ YES ☐ NO
Patient's Primary Care Physician Name	Pharmacy Fax Number ( )
Diagnosis:	**ICD-9 code:**

Medication	**Strength**	**Directions**	**Qty/mth**	**Duration**

Medications Tried and Failed:

Date	Name, Strength & Formulation	Dose	Duration	Outcome
Date	Name, Strength & Formulation	Dose	Duration	Outcome
Date	Name, Strength & Formulation	Dose	Duration	Outcome

Clinical Reasons for requested drug:

Any additional information:

I certify that the above information is correct to the best of my knowledge.

Physician's Signature ______________________ Date ______________

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