

Instructions:

Please complete this form and fax to MedImpact Healthcare Systems, Inc. at (858) 790-7100 or call (800) 788-2949 with this information. Please note that approval is based on medical necessity criteria approved by the County Medical Services Program Governing Board. 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 the formulary agents is contraindicated in the patient.
2. The patient has failed an appropriate trial of the formulary agents.
3. Choices available in the formulary are not suited for the present patient care need and the drug selected is required for patient safety.
4. The use of the formulary agents may provoke an underlying medical condition that would be detrimental to patient care.

URGENT REQUESTS

Please check the box(s) below, if applicable. (**Required if Urgent Request**):

- Medication prescribed on hospital discharge or from an emergency medical visit. Date of discharge/visit: _____
- Therapy in which a delay may result in significant morbidity or mortality

Medication Request Information (please complete each section of this form prior to transmittal):

<u>Patient Name (required):</u>		<u>Physician Name/Specialty (required):</u>	
<u>Patient ID # (required):</u>		<u>Provider DEA Number:</u>	<u>Provider Medi-Cal Number:</u>
<u>Patient DOB (required):</u>		<u>Physician Area Code and Telephone Number (required):</u> () -	
<u>Drug Requested:</u>		<u>Physician Area Code and Fax Number (required):</u> () -	
		<u>Strength:</u>	<u>Dose:</u>
<u>Diagnosis (be specific):</u>		<u>Quantity (per month):</u>	<u>Length of Treatment:</u>
<u>Risk Factors for Gastrointestinal Injury:</u>			
<u>Other Medications Tried and Failed:</u>			
<u>Drug</u>	<u>Dose</u>	<u>Treatment Dates:</u>	<u>Outcome of Trial</u>
<u>Additional Medical Justification for Requested Therapy:</u>			