



**Pharmacy Authorization and Formulary Exceptions Request**

**Fax: (626) 388-2368**

**LEVEL OF SERVICE**

- ROUTINE (72 HRS)
- EXPEDITED (24 HRS: PRESCRIBING PROVIDER MUST ALSO CALL CHMP)

**DATE**

**TO BE COMPLETED BY PRESCRIBING PROVIDER**

PATIENT INFORMATION			PRESCRIBING PROVIDER	
NAME <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			NAME	
ID #	DATE OF BIRTH	AGE	TELEPHONE	FAX
TELEPHONE	PCP		IPA OR GROUP	SPECIALTY
ADDRESS			ADDRESS	

PHARMACY INFORMATION		
NAME		PHARMACIST OR TECHNICIAN
TELEPHONE	FAX	ADDRESS

REQUESTED PRESCRIPTION		
DRUG NAME	STRENGTH OR CONCENTRATION	
ROUTE AND DIRECTIONS	QUANTITY	REFILLS
DIAGNOSIS (ICD-9 CM CODE)	NEW OR INITIAL THERAPY? <input type="checkbox"/> YES <input type="checkbox"/> NO	DURATION OF TREATMENT

SUPPORTING STATEMENT	
REASON FOR REQUEST	
PREVIOUS TREATMENTS TRIED	EXPLANATION OF MEDICAL NECESSITY

<b>PRESCRIBING PROVIDER'S SIGNATURE</b>

CENTRAL HEALTH MEDICARE PLAN USE ONLY	
<input type="checkbox"/> APPROVED <input type="checkbox"/> MODIFIED <input type="checkbox"/> DENIED <input type="checkbox"/> DEFERRED	REVIEWER'S NOTES          <div style="display: flex; justify-content: space-between;"> <span>MEDICAL DIRECTOR OR DESIGNEE'S SIGNATURE</span> <span>DATE</span> </div>