PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: AppleCare Medical Group

Plan/Medical Group Phone#: (800) 460-5051
Plan/Medical Group Fax#: (714) 676-0790

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:	State:	Zip Code:
Date of Birth:	❑ Male ❑ Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg):_____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	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:	[1] Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:
❑ Oral/SL ❑ Topical ❑ Injection ❑ IV ❑ Other:

Administration Location:
❑ Physician's Office ❑ Patient's Home ❑ Home Care Agency ❑ Long Term Care ❑ Other (explain):

❑ Ambulatory Infusion Center ❑ Outpatient Hospital Care

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1. Has the patient tried any other medications for this condition? ❑ **YES (if y complete below)** **NO**

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

2 List Diagnoses:	**ICD-9/1CD-10:**

3. Required clinical information - 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.

❑ Attachments

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:** _____

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Plan Use Only: Date of Decision: _____

❑ Approved ❑ Denied Comments/Information Requested: _____

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