

CareMore Health Plan Prior Authorization/Exception Request
Phone: (562) 622-2825 or (800) 965-1235 Fax: (562) 622-2814 or (800) 589-3149

PATIENT NAME: _____ FACILITY NAME: _____

PATIENT ID: _____ REQUESTING MD NAME: _____

ADDRESS: _____ REQUESTING MD PHONE: _____

PATIENT DOB: _____ REQUESTING MD FAX #: _____

REQUESTING PHARMACY: _____ PHARMACY PHONE/FAX: _____

MEDICATION REQUEST: Standard (48-72 Hours) Expedited (24 hours- By checking this box, I certify the standard review time frame may seriously jeopardize the life or health of the member)

Name & Strength of Medication: _____

Directions: _____ Quantity: _____

(Please check type of request)

Formulary Requires PA Non-Formulary Tier Exception Step Therapy Quantity Limit

DIAGNOSIS ICD-9 CODES:

LIST DATES & MEDICATIONS TRIED/FAILED FOR THIS CONDITION:

PLEASE PROVIDE THE FOLLOWING INFORMATION NEEDED TO REVIEW THIS REQUEST:

Clinical rationale for selected drug usage: _____

- **Dates, Length of therapy, and dosage regimens of trials on alternative**
- **Formulary medications.**
- **Specific clinical/medical documentation of previous treatment failure.**
- **(example: Lab values or supporting clinical measures)**
- **If the provider feels that the member will suffer from an adverse effect, please substantiate this statement w/clinical literature support.**
- **The provider must document why other therapeutically equivalent agents on the formulary do not meet the needs of the patients**

I understand that the False Claims Acts, 31 USC sections 3729-3733, prohibits knowingly and willfully making or causing to be made any false statement or representation of material fact in any application or claim for benefits or payment under a federal healthcare program, including Medicare or Medicaid. I certify that the information provided above for this member is consistent with the patient's medical records.

Requesting Doctor's signature: _____ **Date:** _____