



Form must be fully completed to avoid a processing delay.

For status of a request, call: (800) 548-5524

Patient's Name (Last, First, MI)										Date of Birth ----- MM / DD / YYYY -----									
Member ID # ----- Please print clearly and enter one digit per box -----										Patient's Phone ----- Please print clearly and enter one digit per box -----									
Patient's Address, City, State, Zip										Gender <input type="checkbox"/> M <input type="checkbox"/> F					Allergies				
Provider's Name (Last, First, MI)										Provider Specialty					Contact Name				
Provider's Address, City, State, Zip										NPI #									
----- Provider's Phone ----- Please print clearly and enter one digit per box -----										----- Provider's Fax ----- Please print clearly and enter one digit per box -----									
Medication Name and Strength										Quantity					Direction for Use and Duration				
Administered: <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Home Health <input type="checkbox"/> By Patient <input type="checkbox"/> Other (specify):										Diagnosis									
ICD Code										New Start with This Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No									
If No, Date of First Dose										Medications Previously Tried with Dates of Use									
Medical Justification and Supporting Information (attach labs and/or chart notes as appropriate)																			

For Medicare members only: Please review carefully and complete each applicable subsection.

For all requests: Is the patient currently receiving dialysis? Yes <input type="checkbox"/> No <input type="checkbox"/>																			
For drugs considered to be High Risk Medications (HRM) for the elderly (i.e. drugs on the Beers List), is the patient continuing on this medication without adverse effects? Yes <input type="checkbox"/> No <input type="checkbox"/>										Comment:									
For immunosuppressive medication requests: Is it being used for a transplant? Yes <input type="checkbox"/> No <input type="checkbox"/>										If Yes, Date of transplant:									
For antiemetic medication requests: Will the patient be on any other concurrent antiemetic therapy? Yes <input type="checkbox"/> No <input type="checkbox"/>										Will this drug be used as full therapeutic replacement for intravenous antiemetic drugs within 2 hours and continued for a period not to exceed 48 hours of chemotherapy? Yes <input type="checkbox"/> No <input type="checkbox"/>									
Specify drug(s) & route: _____										For nutritional supplement (enteral or parenteral) medication requests: Does the patient have a G-tube? Yes <input type="checkbox"/> No <input type="checkbox"/>									
Does the patient have a permanent dysfunction of the digestive track? Yes <input type="checkbox"/> No <input type="checkbox"/>																			

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

Physician's Signature										Date									
Name of provider/vendor submitting this form if other than the prescriber above										Phone #									

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Mailing Address: HNPS Prior Authorization Department, 21281 Burbank Blvd Woodland Hills, CA 91367-6607

For copies of prior authorization forms and guidelines, please call (800) 548-5524 or visit the provider portal at www.healthnet.com.