Pharmacy Prior Authorization Form – Injectable
Fax Completed Form to (818) 676-8086

PA forms and guidelines are available on the provider portal of www.healthnet.com

If the fax number provided is not a dedicated machine to you or your staff, please check this box

Patient Name	Date of Birth
Patient's ID Number	Patient's Phone Number ( )

Physician's Name and Specialty	Medical Group Name
Physician's Address	City, State, Zip Code
Physician's Phone Number ( )	Physician's Fax Number ( )
Are you the patient's primary care physician? ☐ YES NO	Has the patient provided an authorized referral? YES NO
Utilization Management Authorization # (attach copy)	Date Medication Needed
Patient's Primary Care Physician Name	Primary Care Physician's Fax Number ( )
Diagnosis:	**ICD-9 code:**

Medication	**Strength**	**Directions**	**Qty/mth**	**Duration**
Administered: Doctor's Office In Dialysis Center By Patient Other: ____________________				

Medications Tried and Failed:				
Date	Name, Strength & Formulation	Dose	Duration	Outcome
Date	Name, Strength & Formulation	Dose	Duration	Outcome

Lab values or other supporting information to establish medical necessity.

I certify that the above information is correct to the best of my knowledge and that I will be supervising the treatment accordingly. I further authorize administration of supplies (syringes, needles) related to therapy.

Physician's Signature ____ Date __________________________

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