



**Pharmacy Prior Authorization Form – Medical Necessity
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	Are you the patient's primary care physician? <input type="checkbox"/> YES <input type="checkbox"/> NO
Physician's Phone Number ()	Physician's Fax Number ()
Pharmacy Phone Number ()	Pharmacy's Fax Number ()
Diagnosis:	ICD-9 code:

Medication	Strength	Directions	Qty/mth	Duration

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

Clinical Reasons for requested drug:

Any additional information:

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

Physician's Signature _____ Date _____

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