Health Net

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? ☐ YES ☐ 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
Date	Name, Strength & Formulation	Dose	Duration	Outcome
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 _____