Health Net of the Northeast

PRIOR AUTHORIZATION / MEDICATION EXCEPTION Request Fax Form

For Status of a Request Call: 1-800-867-6564

FAX TO: 1-800-977-8226

FORM MUST BE FULLY COMPLETED TO PROCESS PRIOR AUTHORIZATION REQUEST. PLEASE PRINT.

Patient's Name (Last, First, MI)	Health Net Member ID #	Date of Birth
Patient's Street Address/City/State/Zip Code	**Home Phone #** ( )	**Allergies**
Provider's Name (Last, First, MI)	**Provider Specialty**	**DEA #**
Provider's Address/City/State/Zip Code		**License #**

------- Provider Phone ----- Please print clearly and enter one digit per box -------	-------- Provider Fax ------- Please print clearly and enter one digit per box --------
( ) –	( ) –

Medication Name and Strength	NDC# or J Code	Quantity	Direction for Use and Duration

Diagnosis (Include ICD-9 Codes)	Date of First Dose, or If Renewal, Date Treatment Began:

Medications Previously Tried	Dates of Use

Medical Justification for Requested Medication

If the medication is an injectable, please indicate where the patient will obtain the medication: From the Provider ☐ From a Pharmacy ☐

Where will the injectable drug be administered: In Provider's Office ☐ Outpatient Facility (first dose only) ☐ Home ☐

Administration in an Outpatient facility may be approved for the first dose only. For subsequent doses, if administered in the Provider's office, will the expense for the drug be incurred by the physician ("incident to the physician service"), or will the drug be supplied to the physician's office by Specialty Pharmacy or Vendor? Physician Expense ☐ Specialty Pharmacy ☐ Other Vendor ☐

(For Medicare Part D members, this information is used to help determine Medicare Part B vs. Part D status)

Medication Vendor Name, if applicable	Participating with HN? Yes ☐ No ☐	Phone	Fax
	Provider ID# if participating provider	Contact Person:	

For Medicare Part D Members: If the medication is an immunosuppressive drug, is it being prescribed for that use? Yes ☐ No ☐

If yes, was the member's organ transplant procedure covered by Medicare? Yes ☐ No ☐

(*Information is used to help determine Medicare Part B vs. Part D status*) Date of transplant: _____

For Nutritional Supplement or Enteral Requests, Please provide/attach:

1) Current chart notes
2) For children, current growth chart
3) Whether the patient uses a G tube: Yes ☐ No ☐
4) Whether the patient requires home health care services: Yes ☐ No ☐

Home Health Provider (HNPS only reviews the authorization for medical necessity of the medication):	Phone #: ( )	Fax #: ( )
Pharmacy Name (Optional):	Phone #: ( )	Fax #: ( )
Physician's Signature	Date	
Name of Provider/vendor submitting this form:	Telephone #	

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. In New York said civil penalties shall not exceed five thousand dollars and the stated value of the claim for each violation.

Mailing Address: HNPS Prior Authorization Department, 10540 White Rock Road #280, Rancho Cordova, CA 95670

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