Health Net

Medicare Prior Authorization / Formulary Exception Request Fax Form

FAX TO: (800) 314-6223

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 ☐ M ☐ 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: ☐ Doctor's Office ☐ Dialysis Center ☐ Home Health ☐ By Patient ☐ Other (specify):	
Diagnosis / ICD Code	New Start with This Medication: ☐ Yes ☐ 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 ☐ No ☐	
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 ☐ No ☐	Comment:
For **immunosuppressive** medication requests: Is it being used for a transplant? Yes ☐ No ☐	If Yes, Date of transplant:
For **antiemetic** medication requests: Will the patient be on any other concurrent antiemetic therapy? Yes ☐ No ☐ Specify drug(s) & route: _____	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 ☐ No ☐
For **nutritional supplement (enteral or parenteral)** medication requests: Does the patient have a G-tube? Yes ☐ No ☐ Does the patient have a permanent dysfunction of the digestive track? Yes ☐ No ☐	

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 #

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.

Revised 08-2015