



PREAUTHORIZATION / MEDICATION EXCEPTION REQUEST FAX FORM

Form must be fully completed to avoid a processing delay.

Patient name (last, first, MI)		Member ID #	Date of birth
Medication name and strength	Quantity	Directions for use and duration	
Is this a new medication for the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date first started: _____	
Diagnosis			ICD-9 Code
Formulary drugs tried / previous therapy			Dates of use
Medical justification for requested drug (include chart notes and supporting labs)			
Physician name (last, first, MI)	MD specialty	Pharmacy name	Pharmacy fax number
			()
Contact person	Date	Contact phone number	Contact fax number
		()	()
More information required (PacificSource use only)			
Decision/Comments (PacificSource use only)			

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