

Health Net Health Plan of Oregon, Inc. Health Net Life Insurance Company horization / Formulary Exception Poguest Fax Form

Prior Authorization / Formulary Exception Request Fax Form

CoverMyMeds is Health Net's preferred way to receive prior authorization requests. Visit www.covermymeds.com/main/prior-authorization-forms to begin using this free service OR FAX this completed form to (800) 255-9198.

Form must be fully completed to avoid a processing delay.			equest, call: (888) 802-7001
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 Code Gender M F Allergies			
Provider's Name (Last, First, MI)		Provider Specialty	Contact Name
Provider's Address, City, State, ZIP Code			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 Dura	tion
Administered: Doctor's Office Dialysis Center Home Health By Patient Other (specify):			
Diagnosis	Code	New Start with This Medic	ation? 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 Yes Comment: the Beers List), is the patient continuing on this medication without adverse effects?			
For immunosuppressive medication requests: Is it being used for a transplant? Yes \(\square\) No \(\square\) If Yes, date of transplant:			
For antiemetic medication requests: Will the patient be on any other concurrent antiemetic therapy? Yes No Specify medication(s) & route: Will this medication be used as full therapeutic replacement for intravenous antiemetic medications 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? No Does the patient have a permanent dysfunction of the digestive track?			
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 #			
The documents accompanying this facsimile transmission may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the information contained in this transmission is strictly prohibited. If you have received this transmission in error, please notify the sender immediately by telephone or by return FAX and destroy this transmission, along with any attachments. Mailing Address: Pharmacy Prior Authorization Department, 13221 SW 68th Parkway, Suite 500, Tigard, Oregon 97223-8328			
For copies of prior authorization forms and guidelines, please call (888) 802-7001 or visit the provider portal at provider.healthnet.com.			