CalOptima
A Public Agency
Better. Together.

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Submit requests to the MedImpact Prior Authorization Center at:

Plan	Fax	Appeal Fax	Call
OneCare HMO SNP (Medicare Part D)	858-357-2556	858-357-2556	800-819-5532
OneCare Connect (Medicare-Medicaid)	858-357-2556	858-357-2556	800-819-5480

What is the urgency?	Request is for a hospital discharge medication?
☐ Standard ☐ Urgent* ☐ Retroactive	☐ Yes ☐ No

***** The prescriber attests that applying the standard turn-around time could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

PATIENT INFORMATION

Patient Name: _____

Patient CalOptima ID #: _____

Gender: ☐ Male ☐ Female DOB: _____

Other Primary Insurance? ☐ Yes ☐ No ☐ Unknown

Name of Primary Insurance: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Specialty: _____

Prescriber NPI #: _____

Prescriber Signature: _____

For Medicare Part D, an enrollee, an enrollee's representative, or an enrollee's prescribing physician or other prescriber may request a coverage determination

PATIENT LOCATION INFORMATION

Patient Location:
☐ Home ☐ B&C ☐ Sub-Acute ☐ SNF ☐ ICF

Name of Facility: _____

Facility Phone #: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy NPI #: _____

Pharmacy Phone #: _____

Pharmacy Fax #: _____

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY
Drug Name: _____ NDC#: _____			

REVIEW CRITERIA:

What is the diagnosis? _____ **OR** ICD-10 code: _____

New Therapy? ☐ Yes ☐ No # Refills? _____ Date of Rx: _____

Medical Justification Supporting Statement *(include formulary drugs that have been tried, why the requested drug is medically required, why formulary drugs would not be appropriate, and applicable labs).*

If applicable, include dates and reason for retroactive authorization requests.

The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.