CalOptima
A Public Agency
Better. Together.

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Submit requests to the Authorization Center at:

	PA Fax	Appeal Fax	Call
Medi-Cal / CalWrap Authorization	**858-357-2557**	**714-954-2280**	**888-807-5705**
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**

Request Type ☐New ☐Renewal ☐Retroactive ☐Appeal	**Call 888-807-5705** for an override if the request is for: ▪ Hospital discharge medication less than 10 days' supply **OR** ▪ LTC admission less than 14 days' supply for brands or less than 30 days' supply for generics

PATIENT INFORMATION	**PRESCRIBER INFORMATION**
Patient Name: _____	Prescriber Name: _____
Patient CalOptima ID #: _____	Prescriber Phone #: _____
Gender: ☐Male ☐Female DOB: _____	Prescriber Fax #: _____
Other Primary Insurance? ☐Yes ☐No ☐Unknown	Prescriber Specialty: _____
Name of Primary Insurance: _____	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	**PHARMACY INFORMATION**
Patient Location: ☐Home ☐B&C ☐Sub-Acute ☐SNF ☐ICF	Pharmacy Name: _____
Name of Facility: _____	Pharmacy NPI #: _____
Facility Phone #: _____	Pharmacy Phone #: _____
	Pharmacy Fax #: _____

☐ Urgent*

***The prescriber attests that applying the standard turnaround 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. Post service requests are not urgent.**

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

MEDICAL INFORMATION

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

New Therapy? ☐Yes ☐No # Refills? _____

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