



A Public Agency

CalOptima

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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Submit requests to the Prior Authorization Center at:

	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

<p>Request Type</p> <p><input type="checkbox"/> New <input type="checkbox"/> Renewal <input type="checkbox"/> Retroactive <input type="checkbox"/> Appeal</p>	<p>Call 888-807-5705 for an override if the request is for:</p> <ul style="list-style-type: none"> ▪ Hospital discharge medication less than 10-day supply OR ▪ LTC admission less than 14-day supply for brand or less than 30-day supply for generics
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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____ Patient CalOptima ID #: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female DOB: _____ Other Primary Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Name of Primary Insurance: _____	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	PHARMACY INFORMATION
Patient Location: <input type="checkbox"/> Home <input type="checkbox"/> B&C <input type="checkbox"/> Sub-Acute <input type="checkbox"/> SNF <input type="checkbox"/> ICF Name of Facility: _____ Facility Phone #: _____	Pharmacy Name: _____ Pharmacy NPI #: _____ Pharmacy Phone #: _____ Pharmacy Fax #: _____

Urgent*

***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. Post service requests are not urgent.**

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

REVIEW CRITERIA:

What is the diagnosis? _____ **OR** ICD-10 code: _____
 New Therapy? Yes No # Refills? _____ Date: _____

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.

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