CalOptima
A Public Agency
Better. Together.

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Submit requests to the Prior Authorization Center at:

	Fax	Appeal Fax	Call
Medi-Cal/ CalWrap	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

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	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 #: _____

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.