

**SAN FRANCISCO HEALTH PLAN  
DRUG PRIOR AUTHORIZATION REQUEST  
CONFIDENTIAL PATIENT INFORMATION**

**Fax To iRx: (630) 536-1241 or (866) 511-2202**

\*\*\* ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED \*\*\*

Please contact 1-800-777-0074 should you have facsimile transmission difficulties.

**URGENT REQUEST (check here)** \_\_\_\_\_ (Fax to urgent fax line (630) 536-1242 or (877) 636-9001 -- Abuse will be monitored. MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. iRx Clinical Pharmacists reserve judgment of urgency and must meet definition above, therefore, please explain reason for urgency below.)

<b>DATE OF REQUEST:</b>	<b>REQUESTING M.D.:</b>
<b>CONTACT PERSON:</b>	<b>MD/PHARM. SIGNATURE:</b>
<b>FAX NUMBER:</b>	<b>PHONE NUMBER:</b>
<b>Medical Group or Clinic:</b>	
<b>Physician Specialty:</b>	<b>Physician DEA#:</b>

TO THE BEST OF MY KNOWLEDGE, THE FOLLOWING INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY FOR THE HEALTH OF THE PATIENT.

<b>PATIENT NAME (Last, First, MI):</b>		<b>DOB:</b>
<b>PATIENT ID #:</b>	<b>SEX: M F</b>	<b>Member Phone #:</b>
<b>Pharmacy Name:</b>		<b>Pharmacy Phone:</b>
<b>Pharmacy Contact:</b>		<b>Pharmacy Fax:</b>

<b>MEDICATION REQUEST</b>			
<b>NEW</b>	<b>RENEWAL</b>	<b>RENEWAL ORIGINAL RX DATE:</b>	_____
<b>RELEVANT DIAGNOSIS:</b>			
<b>LIST FORMULARY DRUGS TRIED <u>AND</u> DESCRIBE MEDICAL REASON FOR REQUESTED DRUG (Please be descriptive):</b>			
<b>DRUG AND STRENGTH:</b>		<b>NDC:</b>	_____
<b>DIRECTIONS:</b>		<b>MONTHLY QTY:</b>	_____
<b>DURATION OF EXPECTED THERAPY</b> _____			
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<b>APPROVED</b>	<b>DENIED</b>	<b>DEFERRED</b>	<b>APPROVED AS MODIFIED</b>
<b>COMMENTS</b>			
<b>VALID:</b>	<b>EXPIRES:</b>	<b>REVIEWED BY:</b>	_____

<b>DATE PROCESSED:</b>	<b>BY:</b>
<b>FAXED TO PHYSICIAN:</b>	<b>FAXED TO PHARMACY:</b>