



San Francisco Health Plan

Phone: 800-626-0072

Fax: 866-511-2202

Prescriber Information

Name: _____ Specialty: _____

DEA/NPI: _____ Phone: _____ Fax: _____

Pharmacy Information

Name: _____ Phone: _____ Fax: _____

Patient Information

Name: _____ Date of Birth: _____ Member ID: _____

Medication Information:

Name and Strength of Drug: _____ Quantity & Dosing: _____

Diagnosis: _____ Duration of Therapy: _____

Medication Request New Renewal ---Renewal Original Rx Date: _____

Prior Authorization Criteria: General (Non-Preferred)

You must answer ALL questions		
1. Has the patient tried/failed an adequate trial of a preferred drug? (Document drug, dates of trials, and description of failures below) _____ _____ _____	Y	N
2. Has the patient experienced an adverse event, or been intolerant to, a preferred drug? (Document drug, dates of trials, and description of failures below) _____ _____ _____	Y	N
3. Is the patient currently taking the requested medication? (If yes, please describe how the medication was supplied) _____ _____ _____	Y	N

Please note any other information pertinent to this request:

Information given on this form is accurate as of this date.

Prescriber or Authorized Signature

Date _____

I understand that Informed Rx's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).