HealthPlan OF SAN MATEO

Medication Request Form (MRF)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Attn: HPSM Pharmacy Services
701 Gateway Blvd., #400
South San Francisco, CA 94080
Phone: 650-616-2088
Fax: 650-829-2045

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

Instructions:
This form is to be used by participating physicians and providers to obtain coverage for a non-formulary (NF) drug for which there is no suitable alternative available. Please complete this form and fax to **HPSM at 650-829-2045**. If you have any questions regarding the prior authorization (PA) process, please contact **HPSM Pharmacy Services at 650-616-2088.**

Review Criteria:
The following criteria are used in reviewing medication requests:
1. The use of Formulary Drug Products is contraindicated in the patient.
2. The patient has failed an appropriate trial of Formulary or related agents.
3. The choices available in the Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
4. The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Name (required):	Physician Name (required):
Patient ID # (required):	Physician Specialty (required): *Please check one*: ☐ - Psychiatry/Mental Health | ☐ - Other
	Physician NPI#/DEA # (required)::
Patient DOB (required):	Physician Area Code and Telephone Number (required): ( ) -
Diagnosis (required):	Physician Area Code and Fax Number (required): ( ) -
Pharmacy used by Member:	Pharmacy Telephone and Fax Number: ( ) - ; ( ) -
Drug Requested *(For Concurrent Atypical Antipsychotic requests, please also submit a Brief Psychiatric Rating Scale – BPRS Form)*	
Dose:	Length of Treatment (**please be specific**):
Strength: Quantity (per month):	Dosage Form (e.g. Oral, Injection):
Reason for Medication Request (**required - please be specific, give detail**):	
Other Medications Tried and/or Failed (**required - please be specific, give detail**):	
Other Pertinent History (**required -** relative or pertaining to this request):	

Physician Signature: _____M.D. **Date**:_____

Revised: Mar 2010 by BC – Version 2010