*XC and Catalyst are now **Catamaran***

San Diego CMS Program
Phone: 800-626-0072
Fax: 866-511-2202

Check here for **URGENT** request: ☐ **Medical** justification for urgent request: ____________________

Completed by: ______________________ **Appeal or reconsideration of denial?** ☐ **YES** ☐ **NO**
Direct Phone #: ______________________ **Has Patient Assistance Program been denied?** ☐ **YES** ☐ **NO**
Has this medication been denied by ADAP? ☐ **YES** ☐ **NO** ☐ **N/A**

Prescriber Information	
Last Name:	First Name
DEA/NPI:	Specialty:
Phone - -	Fax - -

Member Information	
Last Name:	First Name
Member ID Number	DOB - -

Medication Information:	
Drug Name and Strength:	Quantity and Dosing
Diagnosis:	Duration:

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).