



**CenCal Health Use Only**

(Please Print)

Exceeded 7 Rx Monthly Limit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Today's Date
--	--------------

<b>Member ID</b>	Member Name	ID #	Birthdate
	Member Address	Member Phone No.	
	PCP Name	Is patient Medi-Care eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Status <input type="checkbox"/> Home <input type="checkbox"/> Board & Care <input type="checkbox"/> NF/ICF <input type="checkbox"/> Acute Hospital

Prescriber Name	Specialty	Phone No.	FAX No.
DEA #	Medi-Cal No.	NPI #	
Address		City/State/Zip	

**REQUESTED MEDICATION INFORMATION**

Drug Name/Strength (mg)/Dosing schedule	Estimated length of therapy (1 month, etc./why?)
Diagnosis	ICD-9 Code(s)
Request is retroactive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:

**Please explain why you are requesting the use of this medication:**

<b>Previous Medications Tried:</b>	
<u>Medication / Strength</u>	<u>Outcome of Medication Tried</u>

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

Signature of Physician or Prescriber	Title	Date
--------------------------------------	-------	------

**CenCal Health Staff Use Only**

Provider, your request is: <input type="checkbox"/> Approved as requested <input type="checkbox"/> Approved as modified <input type="checkbox"/> Denied <input type="checkbox"/> Deferred	Reviewer's Signature
I.D. #	Date
Comments/Explanation	

Approved Units	NDC#/PMI#/GPI#	Quantity	Specific Services Requested

Authorization is valid for services provided from _____ Date to _____ Date	(S) S7U YFYU GUBU6UFVUFU, CA 9311S (800) 421-2560, Ext. 2229 (805) 685-9525, Ext. 2229 www.cencalhealth.org
--	---

**NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.**

