HealthPAC
Health Program of Alameda County

CLAIM AUTHORIZATION REQUEST FORM

Please fax completed form to HealthPAC HIV at 510-567-6850 TELEPHONE: 510-383-1790

REVIEW REQUEST FOR ACCURACY AND COMPLETE ALL APPROPRIATE FIELDS

PHARMACY INFORMATION

NPI: _____

Contact person: _____

STAMP or **WRITE** Pharmacy Name, Phone & Fax:

PHONE: ( ) _____

FAX: ( ) _____

CLIENT INFORMATION

(Print Clearly)

_____

Last Name First Name

I.D.: _____

D.O. B. _____ / _____ / _____

		Co-Pay or Cash Price	Requested QTY	Days Supply	Prescription Date
RX#1 _____	NDC: _____-_____-_____	$: _____		_____	_____
RX#2 _____	NDC: _____-_____-_____	$: _____		_____	_____
RX#3 _____	NDC: _____-_____-_____	$: _____		_____	_____
RX#4 _____	NDC: _____-_____-_____	$: _____		_____	_____
RX#5 _____	NDC: _____-_____-_____	$: _____		_____	_____
RX#6 _____	NDC: _____-_____-_____	$: _____		_____	_____
RX#7 _____	NDC: _____-_____-_____	$: _____		_____	_____
RX#8 _____	NDC: _____-_____-_____	$: _____		_____	_____

MUST CHECK ALL THAT APPLY

Program Limits
- ☐ Claim over 90 days
- ☐ Reversal request

Quantity Limit
- ☐ CII or CIII Max* **original Rx required*
- ☐ Exceed Max fills (13) per year
- ☐ ARV Daily QTY Max** ***Submit w/Treatment Exception Request (TER) form*
- ☐ ARV Duplicate Therapy** ***Submit w/Treatment Exception Request (TER) form*
- ☐ Day supply >30days
- ☐ Day supply less than minimum required

Early Refill
- ☐ Lost med fill
- ☐ Vacation Supply
- ☐ Change in dose* **original Rx required*

Formulary
- ☐ Code 1 or Diagnosis required
- ☐ Lab results required
- ☐ Step therapy required

Other
- ☐ DAW _____

Notes/Explanation:

* * * *CONFIDENTIAL* * * *

Ramsell