

SummaCare/Apex Medication Request Form Commercial/Marketplace/MEWA

Attn: Prior Authorization Department Fax: 858-790-7100

	RGENT) REVIEW: BY CHECKING THIS DIZE THE LIFE OR HEALTH OF THE MI				
Date:		Time MRF was taken:			
Physician Signature:		Physician Cell Phone #:			
Medication Request Information (please complete each section of this form prior to transmittal): *Denotes Required Fields					
Status					
Patient did not meet Guidelin the following reason:	e # for				
PATIENT INFORMATION		PHYSICIAN INFORMATION			
*Name:		*Name:			
*ID#:		*Specialty:			
*Date of Birth:		*ID# / DEA#:			
*HQ:		*Phone: () -	*Fax: () -	
Diagnosis (ICD-9 Code, if known): PHARMACY INFORMATION (If provided)					
	PHARIVIACT INFORIV	iATION (II p	novidedj		
*Pharmacy Name:		*Phone: () -	*Fax: () -	
REQUESTED DRUG INFORMATION					
*Requested Drug: If this medication is a high risk medication in the elderly, I certify recognition of my awareness					
*Dose:		*Strength:			
*Quantity:	*Dosage Form:		*Length of Treatment:		
(per month)			(Please be specific.)		
Reason for Medication Request (Please be specific, give detail.):					
Other Medications Tried and/or Failed including OTC (Please be specific, give detail. Chart notes preferred):					
Other Pertinent History (Relative or pertaining to this request.):					

**Note: Specialty Vendor for SUM01, 02, 06, 07, 11, 17 is AcariaHealth: 833.626.8417 Specialty Vendor for SUM14 is SummaHealth Specialty Pharmacy: 888.874.8134