

FAX this completed form to 866-399-0929

OR Mail requests to: US Script PA Dept., 2425 West Shaw Avenue, Fresno, CA 93711

Specialty Pharmacy Provider Ship to: Patient Office Other: _____

Name of Specialty Pharmacy Provider: _____

MEMBER INFORMATION	PROVIDER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	NPI#: _____
City, State Zip: _____	Group or Hospital: _____
Home Phone: _____	Address: _____
Alternate Phone: _____	City, State Zip: _____
Date of Birth: _____	Phone: _____
Gender: _____	Fax: _____
	Contact Name: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____ Phone#: _____
 Secondary Insurance: _____ ID#: _____ Phone#: _____

DIAGNOSIS	ADDITIONAL CLINICAL INFORMATION
Please include ICD9 and description _____ _____ _____ _____	Weight: _____ kg/lbs Height: _____ in/cm Lab Data (Please include copies of reports): _____ _____
Date of Diagnosis: _____ (Please include any diagnostic clinicals such as labs, radiology, exams, etc.)	Other Medications: _____ _____
	Additional Comments: _____ _____

Is member currently treated with this medication(s)? No ___ Yes ___ How long: _____

Is this request a continuation of a previous approval by Magnolia Health Plan? No ___ Yes ___

Has the strength, dosage or quantity required per day: Increased _____ Decreased _____ Same _____

MEDICATION(S) REQUESTED

Therapy Start Date: _____

Medication Name	Strength/Dose	Directions	Quantity	Refills

Prescriber's Signature

Date