Apex Medication Request Form
SUM02
Attn: Prior Authorization Department
Fax: 858-790-7100

☐ **REQUEST FOR EXPEDITED (URGENT) REVIEW**: BY CHECKING THIS BOX, I CERTIFY THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

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 Guideline # for the following reason:	

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)		
*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:** (per month)	***Dosage Form:** (Oral, Injection, etc)	***Length of Treatment:** (Please be specific.)

Comments
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 is Walgreens Specialty: 888-347-3416