Medication Request Form (MRF)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Attn: Prior Authorization Department
Address: PO BOX 72010
San Juan, PR 00936-7710
Phone: 1-844-880-8820 or 787-523-2829
Fax: 1-844-997-9950 or 787-523-2843

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Approved:
Denied:
Returned:
PA #

Instructions:
This form is to be used by participating physicians and providers to obtain coverage for a formulary drug requiring prior authorization (PA), a non-formulary drug for which there is no suitable alternative available, or any overrides of pharmacy management procedures such as step therapy, quantity limit or other edits. Please complete this form and fax to **MMM Multi Health** at 1-844-997-9950 or call 1-844-880-8820 with this information. If you have any questions regarding this process, please contact Pharmacy Department at 1-844-880-8820 (Toll Free) or 787-523-2829 (Metro Area).

Review Criteria: The following criteria is used in reviewing medical exceptions:

1. The use of Formulary Drug Products (on FMC and/or LME) is contraindicated in the patient. Include the contraindication for each drug in the FMC/LME.
2. The patient has failed an appropriate trial of Formulary Drug Products (on FMC and/or LME) or related agents. Include type of failure of each drug in FMC/LME.
3. The choices available in the Drug Formulary (on FMC and/or LME) are not suited for the present patient care need and the drug selected is required for patient safety. Include reason for the drug not being suited.
4. The use of a Formulary Drug Product (on FMC and/or LME) may provoke an underlying medical condition, which would be detrimental to patient care. Include the underlying medical condition which could be detrimental to the patient.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Name (required):	Patient's Health Plan (required):
Patient ID # (required):	Physician Name/Specialty:
Patient DOB (required):	Physician Area Code and Telephone Number: ( ) -
Diagnosis (required):	Physician Area Code and Fax Number (required): ( ) -
Pharmacy used by Member:	Pharmacy Area Code and Telephone Number: ( ) -
Drug Requested:	Quantity (per month):
Dose:	Length of Treatment (**please be specific**):
Strength:	Dosage Form (e.g., Oral, Injection)
New Prescription OR Date Therapy Initiated:	Drug Allergies:
Reason for Medication Request (**please be specific, give detail**):	
Other Medications Tried and/or Failed (**please be specific, give detail**):	
Other Pertinent History (relative or pertaining to this request):	

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