MEDICAL SAFETY NET (MSN)
DRUG AUTHORIZATION REQUEST
CONFIDENTIAL PATIENT INFORMATION
****Illegible or Incomplete forms will be returned****

FAX TO: (714) 564-0959 MSN CARE COORDINATION UNIT: (714) 834-3557
URGENT REQUEST? (check here) ☐

Date of Request:	Patient Name (last, first, MI):	MSN Member I.D.:
Sex: Male ☐ Female ☐	DOB:	Phone #: ( )
PRINT Physician Name:	MD office Contact Person:	
Physician DEA or State Lic #:	MD Phone #:	
Signature:	MD Fax #:	
Physician's Specialty:		

Pharmacy Name:	Pharmacy Phone Number: ( )
Pharmacy Contact:	Pharmacy Fax Number: ( )
	Pharmacy NABP #:

MEDICATION REQUEST			
Drug Name & Strength:		Qty:	Days Supply:
Directions for use (Sig):	Refills:	**NDC#:(Required)**	
Expected duration of therapy:			
Date of Service:	☐ NEW therapy OR ☐ CONTINUING therapy (Original Rx date: _____)		

MEDICAL JUSTIFICATION
(All four areas in this section **MUST** be completed by member's healthcare provider or Pharmacist)

Diagnosis (for requested drug and all relevant Dx):

Current Medication(s):

Formulary Drugs Tried & Failed:

MEDICAL JUSTIFICATION:

AUTHORIZATION STATUS (FOR MSN USE ONLY)

☐ **Approved** ☐ **Denied** ☐ **Deferred for Additional Information** ☐ **Patient Not Eligible**

COMMENTS:

Authorizing Signature _____ **Date:** _____

VALID: **EXPIRES:**