Kaiser Permanente Mid-Atlantic States Region (KPMAS)
Medication Request Form (MRF)
Pharmacy Benefits Prior Authorization Help Desk
Phone: 1-866-331-2103 Fax: 1-866-331-2104

Instructions: This form is to be used by participating physicians and providers to obtain coverage for a drug that requires prior authorization or a non-preferred/non-formulary drug for which there is no suitable alternative available. Please complete each section of the form and fax to 1-866-331-2104. The Kaiser Permanente Mid-Atlantic States Region Drug Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

MEMBER INFORMATION		
Patient Name:	**Patient DOB:**	**Patient MRN#:**
PHARMACY INFORMATION		
Pharmacy Name:		**Pharmacy Phone:**
PRESCRIBER INFORMATION		
Prescriber Name:	**Specialty:**	**DEA/NPI#:**
Prescriber Phone:	**Prescriber Fax:**	
Prescriber Address:		
DIAGNOSIS AND MEDICAL INFORMATION		
Medication:	**Strength and Dosage Form:**	**Frequency:**
Quantity per 30 days:	**Length of Therapy:**	
Diagnosis:	**ICD-10 Code(s):**	

RATIONALE FOR REQUEST

☐ **DRUG CHANGED TO SUITABLE ALTERNATIVE (please call/send the new prescription to the pharmacy).**

OR

☐ **DO NOT ACCEPT DRUG CHANGE. Request will not be considered unless a reason below is checked, and details provided.**

- ☐ Use of a preferred/formulary drug is contraindicated (i.e., allergy, adverse reaction) – *details required below*
- ☐ Failed an appropriate trial of preferred/formulary or related agent(s) – *provide medications tried and reason for discontinuance below*
- ☐ Choices available in the drug formulary are not suited for the patient care need and drug selected is required for patient safety – *details required below*
- ☐ Use of preferred drug may provoke an underlying medical condition, which would be detrimental to patient care – *details required below*
- ☐ Patient requests non-preferred/non-formulary product / Patient pays full price for drug
- ☐ If brand of a drug with generic alternative is requested, explain rationale why the generic cannot be used - *details details required below*

[REQUIRED] statement of medical necessity and rationale including medications tried: ______________________________

____

____

____

Completed/Submitted By:	**Phone:**	**Fax:**
Prescriber Name (Print):		
Prescriber Signature (Required):	**Date:**	

Prescriber signature confirms the above information is accurate and verifiable by patient records.

Revised: 8/27/2019

Confidential or Privileged: This communication contains information intended only for the use of the individuals to whom it is addressed and may contain information that is privileged, confidential, or exempt from other disclosure under applicable law. If you are not the intended recipient, you are notified that any disclosure, printing, copying, distribution or use of the contents is prohibited. If you have received this in error, please notify the sender immediately by telephone and then dispose of this communication by shredding or confidential recycling. Thank you.