KAISER PERMANENTE thrive

Pre-TAR Informational Request Form
Pharmacy Care Coordination Team (PCCT)

This form is based on standard criteria and may not be applicable to all patients. Filling out this request will allow us to provide a diagnosis along w/prior, failed drugs. If the pharmacy requires information beyond this, please contact the provider directly.

Fax completed form to **1-877-770-0292**

Email: pharmacy-care-coordination@kp.org

Patient Information

Patient First Name: _____

Patient Last Name: _____

Medi-Cal ID#: _____

Kaiser ID# (if known): _____

Patient DOB: _____

Requesting Pharmacy Information and Requesting Prescriber Information

Prescriber Name: _____

Prescriber NPI **(required)**: _____

Prescriber Phone# (if known): _____

City: _____ Zip Code: _____

Pharmacy NPI: _____

Pharmacy Phone#: _____

Pharmacy FAX#: _____

Please indicate which drug and strength is being requested: _____

Quantity Requested _____ **for** _____ **days supply**

If you have any questions about the process or required information, please contact our pharmacy care coordination team at the email/FAX# listed on the top of this form.

Pharmacy care coordination is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. This form is only intended to assist with the completion of the Treatment Authorization Request required for non-CDL covered drugs.

The document(s) accompanying this transmission may contain confidential health information. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of the documents.

If you agree to the above, please sign here: _____ Authorized Pharmacy Agent

**** PHARMACY CARE COORDINATION TEAM USE ONLY BELOW THIS LINE****

Diagnosis: _____ **ICD-10 Code:** _____

Other Medications tried and failed: _____

_____

_____

PCCT Agent: _____ **Date:** _____

PCCT Agent e-mail: _____