

MEDICAL ASSOCIATES HEALTH PLANS

Phone: (563) 584-3275 (800)-325-7442

Fax: (563) 585-1545

Patient Name: _____ Member # _____

Drug Requested: _____ Dosage: _____

Physician Name: _____ Department: _____

Physician Phone: _____ Fax: _____

Pharmacy Name: _____ Phone: _____

Diagnosis: _____

YES NO (Indicate all that apply):

___ ___ Member entering MAHP from another health plan currently established on medication.

___ ___ Member started on medication during recent inpatient hospitalization.
If yes, please list hospitalization and discharge date. _____

___ ___ Other considerations: (Other medications tried, Allergic reactions, Side effects etc).
Please document: _____

___ ___ Drug interactions precluding the use of formulary medication or step therapy. If yes, list
Interacting drugs: _____

___ ___ If request is for a Non-Formulary medication, or to bypass step therapy, or for any other
reason, please list: _____

___ ___ Member has met step therapy.

Request: Approved PA # _____ # of Fills _____ Redirected Denied

If denied or redirected please give reason: _____

Approved By: _____ Date: _____