

Orange County  
MSI

**MSI DRUG AUTHORIZATION REQUEST  
CONFIDENTIAL PATIENT INFORMATION**

**MSI**

**\*\*Illegible or Incomplete forms will be returned\*\***

FAX TO: (714) 784-7475

CCS PHONE NUMBER: (714) 784-4711

URGENT REQUEST? (check here)

Date of Request:	Patient Name (last, first, MI):	MSI Member ID Number:
Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	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 Fax Number: (    )
Pharmacy Contact:	Pharmacy Phone Number: (    )
Pharmacy NABP #:	

**MEDICATION REQUEST**

Drug Name & Strength:	Qty:	Days Supply:
Directions for use (Sig):	Refills:	<b>NDC#:(Required)</b>
Expected duration of therapy:		
Date of Service:	<input type="checkbox"/> NEW therapy OR <input type="checkbox"/> 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:
<b>MEDICAL JUSTIFICATION:</b>

**AUTHORIZATION STATUS (FOR MSI USE ONLY)**

Approved     Denied     Deferred for Additional Information     Patient Not Eligible

**COMMENTS:** \_\_\_\_\_

**Authorizing Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**VALID:**

**EXPIRES:**