

COUNTY OF ORANGE, CALIFORNIA HEALTH CARE AGENCY BEHAVIORAL HEALTH SERVICES

TREATMENT AUTHORIZATION REQUEST

FOR PAYMENT OF PRESCRIPTION,
CONSULTATION, DIAGNOSTIC or TREATMENT PROCEDURE

Identification Label or MRN

Request the following non-formulary medication OR diagnostic consultation / treatment procedure be arranged for this patient							
Pat	ient Name:	Date of Birth:					
Dia	gnoses: Axis I / II:						
	Axis III:						
Requested Medication, Diagnostic / Consultation / Treatment Procedure:							
Des	cribe diagnostic consult / treatment procedures Clinic Office Staff Only	Medication		MG Dose	Quantity	Days Amount	(typically 30)
	30 days initial meds PBM						
	entry After entry - PONY to Divisional QRT						
	Date:	-					
Medical Necessity Justification:							
	Above medication offers signific	•	•				Medication
	,						tion
	Evaluate for physical condition	•	•			ain below)	Diag Cons
							Diagnostic Consultation
☐ Need for treatment that requires special arrangements. (Explain below)							
							Treatment
							nt
Requested by:			M.D.	Phone #	:		
	Pl	ease print					
	Signature:		M.D.	Date	:		
FOR QUALITY IMPROVEMENT USE ONLY							
	Approved through:	Approved through:					
_		Date					
☐ Comments / Dose or # limits		Medication		MG Dose	Quan	tity Days Amo	unt (typically 30)
	Special Arrangements / Suggested alternatives:						
"Special arrangements" that involve payment to contractors for other than laboratory or pharmacy services must be attached to be approved.							
Α	pproved by:		M.D.	Date	:		
	Authori	zed Signature					