HometownRx®

Medication Request Form

Attn: Prior Authorization Department

10315 Professional Circle Reno, NV 89521
Phone: 1-844-373-0970
Fax: 1-866-521-9916

Instructions:
This form is to be used by participating physicians and providers to obtain coverage for a formulary drug requiring prior authorization (PA), a non-formulary drug for which there is no suitable alternative available, or any overrides of pharmacy management procedures such as step therapy, quantity limit, or other edits. **Please complete this form and attach any pertinent documentation such as chart notes and labs regarding medication requested and fax to HometownRx at (866)-521-9916 or please call (844)-373-0970 with this information**. ***Requests submitted without documentation may be delayed or potentially denied*** If you have any questions regarding this process, please contact HometownRx Customer Service at **(844)-373-0970**

Review Criteria:
The following criteria are used in reviewing medication requests:

1. The use of Formulary Drug Products is contraindicated in the patient.
2. The patient has failed an appropriate trial of Formulary or related agents.
3. The choices available in the Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
4. The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care.

☐ REQUEST FOR EXPEDITED (URGENT) REVIEW: BY CHECKING THIS BOX, I CERTIFY THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Medication Request Information (please complete each section of this form prior to transmittal): *Denotes Required Fields

PATIENT INFORMATION		PHYSICIAN INFORMATION	
*Name:		*Name:	
*ID#:		*Specialty:	
*Date of Birth:		ID# / DEA#:	
*Health Plan:		*Phone: ( ) -	*Fax: ( ) -
*Diagnosis (ICD-9/10 Code, if known):			
REQUESTED DRUG INFORMATION		**PHARMACY INFORMATION**	
*Requested Drug:		Name:	
Dose:	Strength:	Phone: ( ) -	Fax: ( ) -
Quantity: (per month)	Dosage Form: (Oral, Injection, etc)	Length of Treatment: (Please be specific.)	
Reason for Medication Request (Diagnosis, ICD 9/10 code and other pertinent information):			
Other Medications Tried and/or Failed (Please be specific, give detail.):			
Other Pertinent History (Relative or pertaining to this request.):			