



PIMA HEALTH SYSTEM MEDICATION REQUEST FORM

<b>Requests should be faxed to:</b> <b>(520) 243-8242</b>		<b>FOR ASSISTANCE CALL:</b> <b>(520) 243-8232</b>
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DATE: \_\_\_\_\_

PROVIDER NAME: \_\_\_\_\_ PHONE \_\_\_\_\_

FAX: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
(Please Print)

AHCCCS ID#: \_\_\_\_\_

MEDICATION NAME AND DOSE: \_\_\_\_\_

DURATION OF THERAPY: \_\_\_\_\_

*REASON FOR EXCEPTION REQUEST: (Please provide indication for use, other therapies tried and reason for failure, and attach any applicable documentation i.e., laboratory results.)*

**Diagnosis:**  **ICD-9:**

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SIGNATURE OF REQUESTING PROVIDER: \_\_\_\_\_

\*\*\*\*\*FOR PHS USE ONLY\*\*\*\*\*

**Approved**                       **Denied**                       **More Information Required\*\***

EFFECTIVE: \_\_\_\_\_ EXPIRES: \_\_\_\_\_

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

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**\*\*Additional information must be submitted within 14 days or request will be denied.**

PHS Signature: \_\_\_\_\_ DATE: \_\_\_\_\_