

EMERGENCY MEDICATION SUPPLY

USE THIS FORM ONLY IF THE EMERGENCY PRIOR AUTHORIZATION CODE IS NOT AVAILABLE AND NOT RECEIVING THE MEDICATION COULD RESULT IN DISABILITY, DEATH, PERMANENT LOSS OF FUNCTION, OR FOR ALLEVIATION OF SEVERE PAIN.

Fax to: (209) 762-4704

PATIENT

Name <i>Last Name, First Name</i>	
HPSJ Mbr ID# or SSN:	
DOB: / /	Sex: M <input type="checkbox"/> F <input type="checkbox"/>

Affix prescription label

NDC # _____ ***** Request can not be processed without a valid NDC#**

Qty: _____

WHEN TO USE THIS FORM:

HPSJ will reimburse any pharmacy who uses this form to dispense medications to members in good faith.

After hours, weekends and holidays, at the professional judgment of the pharmacist, an emergency supply of the medication, **up to 5 days**, may be dispensed for **the alleviation of severe pain and the treatment of unforeseen medical conditions, which, if not treated immediately would lead to disability or death.**

A 3-day supply can be processed by submitting the code **9999998** in the prior auth code field. Please see the full policy on the emergency supply PA code on the HPSJ website. If the code or other systems are not functioning, please use this form as a manual paper claim. HPSJ will review on the next business day and enter an auth so the pharmacy can receive a paid claim.

Please briefly explain the justification for the emergency fill.

Pharmacist Name: (Please print)	Signature:	Date
Pharmacy Phone:	Pharmacy Fax:	