Health Plan of San Joaquin

PHARMACY OVERRIDE FORM

USE THIS FORM ONLY IF THE 3-DAY OVERRIDE CODE IS NOT AVAILABLE OR AN EXTENDED DAY SUPPLY IS NEEDED DUE TO PROVIDER AVAILABILITY 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 *Last Name, First Name*	*Affix prescription label*
HPSJ Mbr ID# or SSN:	
DOB: / /	Sex: M ☐ F ☐

NDC # _____ ***** Request cannot be processed without a valid NDC#**

Qty: _____ **Day Supply: _____**

WHEN TO USE THIS FORM:

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

At the professional judgment of the pharmacist, an emergency supply of the medication **up to 7 days (or one package if unbreakable)** 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, death or severe pain.**

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 this claim form on the next business day and enter an authorization request so the pharmacy can receive a paid claim.

Please briefly explain the justification for the emergency fill.

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

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