Exhibit L
RFP No. 952-5067
Addendum I

Health Net

Health Net
Pharmacy Benefit Services

MEDI-CAL PRIOR AUTHORIZATION REQUEST FAX FORM

FAILURE TO FILL FORM OUT COMPLETELY MAY DELAY AUTHORIZATION

DATE_____

PATIENT NAME (LAST) (FIRST) (MI) MEMBER ID # DATE OF BIRTH

REQUESTING DOCTOR SPECIALTY (Area Code) PHONE NUMBER (Area Code) FAX NUMBER

MEDICATION / STRENGTH QUANTITY DIRECTIONS FOR USE AND DURATION

DIAGNOSIS

MEDICATIONS TRIED / PREVIOUS THERAPY DATE OF USE

MEDICAL JUSTIFICATION FOR REQUESTED DRUG

*** IF TO BE FAXED TO A PHARMACY, PROVIDE FAX NUMBER: (Area Code) _____ ***

DO NOT WRITE BELOW THIS LINE

YOUR REQUEST IS: ( ) APPROVED AS REQUESTED ( ) DENIED ( ) APPROVED AS MODIFIED ( ) PENDING

( ) PLEASE VERIFY PATIENT'S ID # AND NAME ( ) MEDICATION IS EXCLUDED FROM INDIVIDUAL PLANS

( ) MEMBER IS NOT ELIGIBLE — PLEASE CONTACT CUSTOMER SERVICE 1-800-675-6110

( ) PRIOR AUTHORIZATION IS NOT REQUIRED FOR THIS MEDICATION

( ) MORE INFORMATION REQUIRED (IF ADDITIONAL INFORMATION IS NOT PROVIDED WITHIN 72 HOURS THE REQUEST IS CONSIDERED WITHDRAWN)

COMMENTS / EXPLANATION:_____

BY: _____
HNPS PHARMACY CONSULTANT DATE EXPIRATION DATE

Pharmacy or prescriber may call 1-800-867-6564 regarding this form. Members should be referred to their member services department.

FAX TO: 1 - 800 - 977 - 8226