



**VENTURA COUNTY
HEALTH CARE AGENCY**

LIHP/ACE MEDICATION OVERRIDE AUTHORIZATION REQUEST FORM

Requested by (provider) _____ Date of request _____

Referring Clinic _____

Clinic Phone Number _____ Clinic Fax Number _____

Patient Name _____ ACE Member # _____

Patient DOB _____ Diagnosis _____

Medication(s)/Dose/Route/Frequency/Quantity for the month:

Reason for non-formulary prescription/medication over-ride:

FOR ACE/LIHP OFFICE USE ONLY

Tier 1 Approved indefinitely _____

Tier 2 Approved for 2 months, then PAP _____

Tier 3 Approval with PAR _____

Provider notified of non-approval and reason _____ Date _____

E-Scripts notified: Date _____ Over-ride Period _____

Comments _____

Signature _____ Date _____

ACE/LIHP Program
3170 Loma Vista Road
Ventura, Ca 93003
Medication line: 805-641-4429
Fax: 805-648-3311