CareOregon Advantage

PRIOR AUTHORIZATION / FORMULARY EXCEPTION
Request Form
Fax to: 503-416-8109

For assistance with this form, call CareOregon Advantage at 503-416-4279 or toll-free at 888-712-3258, Monday - Friday from 8AM - 8PM

URGENT REQUEST – Initial response within 24 hours: By selecting expedited review and signing below, I certify that applying the standard review time (up to 72 hours) would seriously jeopardize the life or health of the member, or the member's ability to regain maximum function.

Patient Information (Required)	Prescriber Information (Required)
Patient name:	Prescriber name and specialty:
Member ID:	Prescriber DEA/NPI:
Date of birth:	Office phone:
Patient phone:	Office fax:
Medication allergies: NKDA	Contact person:

Medication Information (Required):

Medication requested:		Strength:	Dosage form:
New prescription or Continuation of therapy	Check only if requesting brand	Quantity:	Days supply:
Directions for use:		Diagnosis (ICD-10) associated with medication:	

Clinical Information (Required):

List contraindicated or previously tried drugs. For non-formulary medications, all available formulary alternatives must be addressed.

Drug:	Dose and Duration:	Outcome of Trial:

Clinical Rationale and Medical Necessity Statement (Attach supporting medical records):

Quantity Limit Exceptions

Reason for exceeding the plan limitations (check one):

- Titration or loading dose
- Patient is on dose-alternating schedule
- Requested strength/dose is not commercially available
- Other (Please Specify):

Opioid Safety Restrictions (Complete Section I or II Below)

I. Member has an exemption to the plan opioid safety restrictions (check one):

- Actively enrolled in hospice
- Actively enrolled in palliative care
- Chronic pain due to cancer; active or history of
- Sickle cell anemia diagnosis

II. No Exemption applies – provider attests that treatment is still intended and medically necessary (check all that apply):

Concurrent Therapy
Provider attests that the following concurrent therapy is intended and medically necessary (check one):

- Buprenorphine + opioid
- Benzodiazepine + opioid
- Prenatal vitamin + opioid
- Concurrent use of two long-acting opioids

Opioid-Naïve - Request to fill > 7 days supply of an opioid (check one):

- Provider attests that patient is opioid-naïve and > 7 days supply is intended and medically necessary
- Provider attests that patient is not opioid-naïve

High MME (morphine milligram equivalent)
Patient's total cumulative **MME** exceeds plan limit of 90mg or greater. Provider attests that the following **MME** is intended and medically necessary:

Prescriber's Signature:	**Date:**

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return FAX) immediately and arrange for the return or destruction of these documents.