PRIOR AUTHORIZATION / FORMULARY EXCEPTION

Request Form Fax to 503-416-8109

(Revised on 1/30/2018)



315 SW Fifth Avenue Portland, OR 97204 503-416-4279 or 1-888-712-3258 (TTY/TDD) 7-1-1

For assistance with this form, call CareOregon Advantage at 503.416.4279 or toll-free at 888.712.3258, Monday through Friday from 8 am - 8 pm. Please mark URGENT only as necessary as it delays the review of other requests that may seriously jeopardize the health of another member.

To view what drugs are covered or alternatives on our CareOregon Advantage Formulary List or view our drug policies at Prior Authorization Criteria and Step Therapy Criteria.

** Please complete all fields legibly and we recommend providing supporting medical records **

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☐ URGENT REQUEST Initial response within 24 standard review time of up to 72 hours will seri	hours: By selecting the cously jeopardize the life o	expedited review or health of the m	and signing this fo ember or the mem	rm below,I certify that applying the her's ability to regain maximum function.
Patient Information		Prescriber Information		
Patient Name:		Prescriber Name and Specialty:		
Member ID:		NPI or DEA:		
Gender: Male Female		Office Phone:		
Date of Birth:		Office Fax:		
Patient Phone:		Contact Person:		
Diagnosis And Medical Information Related To Request				
Medication: DAW (Brand Only)	Strength / Route of Administration:		Frequency:	
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:		Quantity:	
Height: Weight:	Drug Allergies: Diagnosis (ICD		10):	
Rationale For Exception Request Or Prior Authorization				
List alternate drug(s) contraindicated or previous	sly tried, but with adverse	e outcome(s) (e.g.	toxicity, allergy or	therapeutic failure):
(1) Drug tried; (2) adverse outcomes for each; (3) dose and duration of therapy on each drug:				
(1)	(2)		(3) _	
(1)	_ (2)		(3)	
(1)	(2)(3		(3)	
Clinical rationale for treatment and statement of medical necessity: (Attach supporting medical records)				
Pertinent laboratory tests and results: (Attach copies of results)				
Prescriber's Signature:	Date:	Date:		

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