# Prior Authorization / Formulary Exception Request Form

**Revised January 2018 • Please fax form to 503-416-8109**

**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, see our *CareOregon Advantage Formulary List* or view our drug policies at *Prior Authorization Criteria and Step Therapy Criteria*.

**Fax to: 503-416-8109**

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

☐ **Urgent Request:** By selecting the expedited review and signing this form below, I certify that applying the standard review will seriously jeopardize the life or health of the member. **Both standard and urgent requests will be reviewed within 24 hours.**

## Patient information

Patient name: ____________________

Member ID: ____________________

Gender: ☐ Male ☐ Female

DOB: ______/______/______

Patient phone: ____________________

## Prescriber information

Prescriber name and specialty: ____________________

NPI or DEA: ____________________

Office phone: ____________________

Office fax: ____________________

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 previously tried, but with adverse 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) __________

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:** __________

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