



INJECTABLE AUTHORIZATION FORM – Revised 12/7/11
 CareOregon Advantage (Plus/Star) and OHP (Plus/Standard) Members
 Please fax form and chart notes to **503-416-4722**

Please verify that the medication requires an authorization before completing the authorization request form.

A list of injectable medications requiring authorization can be located on the CareOregon website.

<http://www.careoregon.org/Providers/ProviderFormsandPolicies.aspx>

If an **inpatient** hospital admission is required, do **NOT** complete this form!

Complete the CareOregon **“Facility Authorization Form”** located on our website.

1. PERSON COMPLETING THE FORM /SIGNATURE OF PRESCRIBING PROVIDER				
Date:		Name:		
Phone #:			Fax #:	
Signature of Prescribing Provider:				
2. MEMBER INFORMATION				
Last Name:		First Name:		MI:
DOB:		Member ID#:		Weight:
<input type="checkbox"/> OHP Plus <input type="checkbox"/> OHP Standard <input type="checkbox"/> Advantage Plus <input type="checkbox"/> Advantage Star				
3. PROVIDER INFORMATION				
Provider Name:			Clinic:	
Provider Phone #:			Provider Fax #:	
4. DIAGNOSIS				
Primary ICD-9 Code:			Secondary ICD-9 Code:	
List additional pertinent history including medications tried and failed and/or any comorbid conditions. <u>Please include relevant chart notes with this request!</u>				
5. REQUESTED DRUG(S) TO BE INJECTED				
HCPC/J-code	# Units	Drug Name	Dose	Frequency
1.				
2.				
3.				
4.				
Start Date:			Duration:	
6. ADDITIONAL OFFICE SERVICES/PROCEDURES IN CONJUNCTION WITH INJECTION				
CPT Code(s):			# Visits:	
7. IF PLACE OF SERVICE IS A FACILITY – Fill out this section of the form				
Facility Name:			Anticipated or Actual Admit Date, if known:	
Check one of the following: <input type="checkbox"/> Infusion Center <input type="checkbox"/> Ambulatory Surgery Center (ASC) <input type="checkbox"/> Hospital Day Patient				