

Prior Authorization Request

Office Injectable Billed to the Medical Benefit

*** Fax to 503 416-1428 ***



CareOregon

315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
877-416-4161 (TTY/TDD)
www.careoregon.org

<u>Date</u>	
<u>Member Name</u>	<u>Member DOB</u>
<u>Member ID</u>	<u>Member PCP</u>
<u>Physician Name</u>	<u>Physician DEA</u>
<u>Physician Phone Number</u>	<u>Physician Fax Number</u>
<u>Place of Service</u>	<u>Please indicate if charges will be for:</u> <u> </u> FACILITY or <u> </u> OFFICE
Requested Drug	
<u>HCPC:</u>	<u>Frequency:</u>
<u>Drug Name:</u>	<u>Duration:</u>
<u>Dose:</u>	<u>Start Date:</u>
<u>Diagnosis</u>	
<u>Other Pertinent History, Medications Tried and Failed:</u>	
<u>Signature of person submitting request</u>	