CareOregon
315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
800-735-2900 (TTY/TDD)
www.careoregon.org

PRIOR AUTHORIZATION / FORMULARY EXCEPTION

Request Form

FAX to 503-416-8109

* For assistance with urgent requests Monday to Friday 8 a.m. to 5 p.m., call CareOregon at 800-224-4840 or 503-416-4100. For assistance after hours, call Express Scripts at 877-526-2313. *

**** Only one medication request per form ** All fields must be completed and legible for review ****

☐ **URGENT REQUEST:** By selecting the expedited review and signing this form below, I certify that applying the standard review time frame will seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Patient Information	Prescriber Information
Patient Name:	Prescriber Name and Specialty:
Member ID#:	DEA#:
Sex: ☐ 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-9):

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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