Injectable Medication Administered by Provider Authorization Form

CareOregon Advantage and OHP Members
Please fax form and chart notes to 503-416-4722

Use this form if ALL of the following are met:

☐ Med is administered by a healthcare professional
☐ Med will be furnished by the provider
☐ Med will be billed directly by the provider

DO NOT use this form if ONE of the following is met:

☐ Medication will be dispensed by a pharmacy
☐ Request is chemotherapy (Use Chemo PA form)
☐ Inpatient hospital admission (Use Facility Form)
☐ Home Infusion/Home Health (Use DME/HH/EPIV form)

Per CareOregon policy, medications administered directly by a medical professional must be billed as medical, unless there is documentation stating why it must be dispensed by a pharmacy AND submitted via Pharmacy PA form.

List of Injectable Meds that require PA, see Policy & Other Forms: *Injectables/Medication Administered Under Medical Benefit.*

Turn-Around Time Requested: ◯ Specified Date (if possible): _____ **OR** ◯ Urgent/Life Threatening (72 hours)

Member Information

Last Name: _____ First Name: _____ MI: _____

DOB: _____/_____/_____ Gender: _____ Member ID#: _____ Weight: _____

Provider Information/ Prescriber Signature

Provider Name: _____ Clinic: _____

Provider Phone#: _____ Provider Fax#: _____

Signature of Prescribing Provider: _____

Person Completing the Form

Date: _____ Name: _____

Phone: _____ Fax: _____

Diagnosis

Primary ICD-10 Code: _____ Secondary ICD-10 Code: _____

List additional pertinent history including medications tried and failed and/or any comorbid conditions.

For thorough review we recommend provide supporting medical records.

Requested Drugs to be Injected

	HCPC/J-code	# Units	Drug Name	Dose	Frequency
1					
2					
3					
4					
Start Date:				Duration:	

Additional Office Services/Procedures in Conjunction with Injection

CPT Code(s): _____ #Visits: _____

Place of Service

Facility Name and Tax ID: _____ Anticipated or Actual Admit Date: _____