

# Prior Authorization / Formulary Exception Request form

Revised May 2022 • Please fax form to 503-416-8109



CareOregon®

To find out if a drug is covered or what would be covered on the formulary as an alternative, search through the **CareOregon OHP Formulary**. To view our drug policies, search through the **OHP PA Use Criteria**.

For assistance with this form, you may call CareOregon at 503-416-4100 or 800-224-4840 — Monday through Friday from 8 am - 5 pm. CareOregon requests careful selection when checking urgent as it delays review of other requests that may seriously jeopardize the health of another member, please mark URGENT only as necessary.

**Please complete all fields with one medication legibly and we recommend providing supporting medical records. CareOregon reviews all requests within 24 hours.**

**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	Prescriber information
Patient name: _____	Prescriber name and specialty: _____
Member ID: _____	NPI or DEA: _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Office phone: _____
DOB: _____/_____/_____	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-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): \_\_\_\_\_

\_\_\_\_\_

<b>Prescriber's signature:</b> _____	<b>Date:</b> _____
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