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

Patient name: _____

Member ID: _____

Gender: ☐ Male ☐ Female

DOB: _____/_____/ _____

Patient phone: _____

Prescriber information

Prescriber name and specialty: _____

NPI or DEA: _____

Office phone: _____

Office fax: _____

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): _____

Prescriber's signature: _____ **Date:** _____