

Plan name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Phone: [ ] - [ ] - [ ] Fax: [ ] - [ ] - [ ]  
 Email: \_\_\_\_\_

**Is this request urgent?** Defined as: A delay of service could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function. –Or– In the opinion of a physician with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the disputed care or treatment. If this request is urgent and meets the definition as indicated above, please check this box.

**Urgent request**

**Instructions:** This pre-authorization request form should be filled out by the provider. Before completing this form, please confirm the patient’s benefits and eligibility. Benefits for services received are subject to eligibility and plan terms and conditions that are in place at the time services are provided.

**Uniform Prior Authorization  
Prescription Request Form**

Date: [ ] / [ ] / [ ]

Verify with the preauthorization list on <https://client.formularynavigator.com/Search.aspx?siteCode=5971235879>, according to the company's procedure, or call the number on the back of the member's card.

Is this request:  New  Authorization extension  Providing additional information

If you already have an authorization number, list it here: \_\_\_\_\_

**1. Patient information**

**Name** Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Member ID #: \_\_\_\_\_ and Group number: \_\_\_\_\_

Secondary insurer member ID #: \_\_\_\_\_ and Group number: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_  Male  Female DOB: [ ] / [ ] / [ ]

Allergies: \_\_\_\_\_

**2. Prescriber / Provider information**

Check one: You are the  Requesting provider  Servicing provider  Specialty: \_\_\_\_\_

Provider: name: \_\_\_\_\_ Tax ID number: \_\_\_\_\_

Phone: [ ] - [ ] - [ ] Fax: [ ] - [ ] - [ ]

NPI: \_\_\_\_\_ DEA number (if required): \_\_\_\_\_

Provider address: \_\_\_\_\_

Who should we contact if we require more information? Name: \_\_\_\_\_

Phone: [ ] - [ ] - [ ] Fax: [ ] - [ ] - [ ]

### 3. Patient's PCP information (if applicable)

Name: \_\_\_\_\_  
Phone:  -  -  ext.  Fax:  -  -

### 4. Medication / Medical and Dispensing Information

Medication name: \_\_\_\_\_  
Dose/strength: \_\_\_\_\_ Frequency: \_\_\_\_\_ Length of therapy/#refills: \_\_\_\_\_ / \_\_\_\_\_ Quantity: \_\_\_\_\_  
 New therapy  Renewal If Renewal: date therapy initiated  /  /   
Route of administration:  Oral/SL  Topical  Injection  IV  Other: \_\_\_\_\_  
Administered:  Doctor's office  Dialysis center  Home health  By patient  Other: \_\_\_\_\_

#### List of previous drugs tried

Drug name:	Dosage:
_____	_____
_____	_____
_____	_____

Provide the medical rationale for requested drug (include chart notes and supporting labs) and why a formulary alternative is not acceptable:

\_\_\_\_\_

\_\_\_\_\_

Provide all ICD-9 or ICD-10 codes and their descriptions, if available; this will help us process your request.

Diagnosis: \_\_\_\_\_  
Codes and descriptions are:  ICD-9  ICD-10  
Primary: \_\_\_\_\_  
Second: \_\_\_\_\_  
Third: \_\_\_\_\_

**Submit the following clinical information with this form as appropriate for this request:** •History & Physical • Lab/radiology/testing results • Current symptoms and functional impairments • Treatment history • *Any other information such as chart notes that support medical necessity for the request.*

<https://client.formularynavigator.com/Search.aspx?siteCode=5971235879>

**Pharmacy Contact Information:**  
Fax: 503-574-8646 or 800-249-7714  
Mail: Attn:Pharmacy Services  
PO Box 3125  
Portland, OR 97208

**Questions Please Call:**  
503-574-7400 or  
877-216-3644