Plan name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: ___ - ___ - ___ Fax: ___ - ___ - ___

Email: _____

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.

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**

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 (inlude 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