CareOregon Advantage
315 SW Fifth Avenue
Portland, OR 97204
503-416-4279 or 1-888-712-3258
(TTY/TDD) 7-1-1

PRIOR AUTHORIZATION / FORMULARY EXCEPTION

Request Form

Fax to 503-416-8109

(Revised on 1/30/2018)

For assistance with this form, call CareOregon Advantage at 503.416.4279 or toll-free at 888.712.3258, Monday through Friday from 8 am - 8 pm. Please mark URGENT only as necessary as it delays the review of other requests that may seriously jeopardize the health of another member.
To view what drugs are covered or alternatives on our CareOregon Advantage Formulary List or view our drug policies at Prior Authorization Criteria and Step Therapy Criteria.

**** Please complete all fields legibly and we recommend providing supporting medical records ****

☐ **URGENT REQUEST Initial response within 24 hours:** By selecting the expedited review and signing this form below,I certify that applying the **standard review time of up to 72 hours** will seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Patient Information	Prescriber Information
Patient Name:	Prescriber Name and Specialty:
Member ID:	NPI or DEA:
Gender: ☐ Male ☐ Female	Office Phone:
Date of Birth:	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)

_____

_____

Prescriber's Signature:	Date: