



# Pharmacy Prior Authorization Request

Phone: 541-431-1985

Fax: 541-302-8052

Medically Urgent

**Instructions for Completion:**

- Please print clearly.
- Complete all boxes marked with \* - requests with incomplete \* areas will be returned without processing.
- Attach clinical notes, lab results, imaging results, etc., to support request.

*Date	*Office Contact Person	*Phone #	*Fax #	
*Member ID#	*Member Name	*DOB		
*Prescriber/Provider Name			<input type="checkbox"/> Workers Comp <input type="checkbox"/> Accident/ Injury Related <input type="checkbox"/> SNF	
Other Insurance ID#	Effective Date	Carrier		Group

## Pharmacy Request (Oral, Topical, Self-injectable)

*Pharmacy	*Pharmacy Location	*Phone	*Fax
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*Dx codes pertinent to this request	*Code Description
1. ____ . ____	
2. ____ . ____	
3. ____ . ____	
4. ____ . ____	

*Medication Name	*Strength	*Quantity	*# of Fills	Retro?
1.				Y <input type="checkbox"/> N <input type="checkbox"/>
Comment:				
2.				Y <input type="checkbox"/> N <input type="checkbox"/>
Comment:				

### For LOHP Use Only

<b>Status:</b> <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Office Contacted <b>Comments:</b>  <b>Medical Director or Designee</b> _____ <b>Date</b> _____
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Approval is not a guarantee of payment. Benefit eligibility must be in effect at the time services are rendered and all plan provisions will apply.