Prescription Drug Prior Authorization Request Form



This form is to be completed by the prescribing provider and staff. Please complete in full to avoid a processing delay. Fax completed forms.

Patient Information					
Patient's Name (Last, First, MI):					
Member ID:		Date of Birth:			
Requesting Provider Information					
Requesting Physician/Provider's Name:			Specialty:		
NPI:	Tax ID No	.:			
Address:	ı				
Phone:	Fax:				
Contact Name:	Phone:		Fax:		
Pharmacy Name:	Phone:		Fax :		
Di	rug Inf	ormation			
Requested Drug Name/Strength:	Qty.:		ICD-9:		
Directions:	Length of	Therapy:	Diagnosis:		
List of previous drugs tried (The formulary is available at www. for a copy.)	providenc	e.org/healthplans (choose "Membe	ers," then "Pharmacy Resources," or call		
Drug Name:	Dosage:				
Provide the medical rationale for requested drug (include char	t notes ar	nd supporting labs) and why a forr	nulary alternative is not acceptable:		
Requesting Provider's Signature:			Date:		
STRICT CONFIDENTIALITY IS MAINTAINI	ED FOR	ALL MEDICAL INFORMA	TION AND REQUESTS.		
Any additional information needed will be requested via telephone					

Any additional information needed will be requested via telephone or fax. Your office will be notified by fax of approval or disapproval; the patient will be notified in writing if this request is <u>not</u> approved.

Providence Health Plan ATTN: Pharmacy Services 3601 SW Murray Blvd., Ste. 10C	Fax 503-574-8646 or 800-249-7714	Questions 503-574-7400 or 877-216-3644
Beaverton, OR 97005	202 27 1 20 10 31 000 2 13 77 11	