Drug Prior Authorization Request Form

PROVIDENCE Health Plan

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:		
Phone:	Fax:	
Contact Name:	Phone:	Fax:
Pharmacy Name (For Prescription Drugs):	Phone:	Fax:
Medical Drug Information (if applicable)		
Site of Care Location:	Start Date:	
Address:		
Phone:	NPI:	Tax ID:
Drug Information		
Requested Drug Name/Strength:	ICD-10:	
Quantity:	Directions:	Length of Therapy:
List of Drugs Previously Tried (Formularies are available at https://healthplans.providence.org/members/)		
Drug Name:	Dosage:	

Provide the medical rationale for the requested drug. Please attach chart notes with your request.

_____

_____

☐ Urgent Request

Requesting Provider's Signature: _____ Date:_____

STRICT CONFIDENTIALITY IS MAINTAINED FOR ALL MEDICAL INFORMATION AND REQUESTS.

Any additional information needed will be requested via telephone or fax. Your office will be notified by fax of the decision.

Providence Health Plans ATTN: Pharmacy Services PO Box 3125 Portland, OR 97208	Fax 503-574-8646 or 800-249-7714	Questions Please Call 503-574-7400 or 877-216-3644

www.providence.org/healthplans

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡くださいゐ!

ةظوحلم اذإ:ت نك ث دحتت ركذا اللغة،نإف ت امدخ ةدعاسملا ةيوغلا رفاوتت كل ناجملا ب ًاصل برقم 1-800-878-4445

(مقر ف تاه مصلا مكبلاو: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

របយ័តនះ េបេើសិនជាអនកនិយាយ ភាសាែខមរ, េសវាជំនួយែផនកភាសា
េដាយមិនគិតឈន លួ
គឺអាចមានសំរាប់ នក។ ចូរ ទូរស័ព 1-800-878-4445 (TTY: 711) ។
បំេរអើ

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

ب يريد دهگ. شام بی ر گ ارينا صب ر وبز ی نا س ت ي تلا ک يد، ن می گ ذ فگ ر فی سرا بز نا ب گ ر :و ت
ف می شا ب . ب (TTY: 711) 1-800-878-4445 ت سا

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคณพดภาษาไทยคณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)