Prescription 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:	Phone:	Fax :
Drug Information		
Requested Drug Name/Strength:	Qty.:	ICD-9:
Directions:	Length of Therapy:	Diagnosis:
List of previous drugs tried (The formulary is available at **www.providence.org/healthplans** (choose "Members," then "Pharmacy Resources," or call for a copy.)		
Drug Name:	Dosage:	

Provide the medical rationale for requested drug (include chart notes and supporting labs) and why a formulary alternative is not acceptable:

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 approval or disapproval; the patient will be notified in writing if this request is not approved.

Providence Health Plan ATTN: Pharmacy Services 3601 SW Murray Blvd., Ste. 10C Beaverton, OR 97005	**Fax** 503-574-8646 or 800-249-7714	**Questions** 503-574-7400 or 877-216-3644

www.providence.org/healthplans