

**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, patient will receive medication in clinic)		
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 <a href="https://www.providencehealthplan.com/members/pharmacy-resources">https://www.providencehealthplan.com/members/pharmacy-resources</a> )		
Drug Name:	Dosage:	

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

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	<b>ATTENTION:</b> For prescriptions obtained at a pharmacy, electronic PA can be submitted via either <b>CoverMyMeds or SureScripts</b>
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