

physician drug prior authorization form



This form is to be completed by the prescribing physician and staff.

- The prior authorization drug list is available at: www.providence.org/healthplans/pharmacy
- The physician should FAX the completed Drug Authorization form to the FAX number below

PATIENT'S NAME.		MEMBER ID NO.
PHYSICIAN'S NAME	PHYSICIAN'S PHONE #	
OFFICE CONTACT AND PHONE #	FAX #	

If you would like us to notify the pharmacy if the PA is approved, both the following are required:

PHARMACY NAME	PHARMACY FAX
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In order to process the Drug Authorization request, supporting documentation is required:

DIAGNOSIS	ICD-9 CODE (MANDATORY)
DRUG NAME	

List below other formulary medication(s)* the member has tried and failed:

*The formulary is available at www.providence.org/healthplans/pharmacy or call for a copy

Provide below or attach medical rationale why a formulary alternative is not acceptable:

What is the anticipated duration of requested therapy? _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

STRICT CONFIDENTIALITY IS MAINTAINED FOR ALL MEDICAL INFORMATION AND REQUESTS.

- ◆ Telephone/fax contact will occur if more information is needed.
- ◆ The physician office will be notified by fax of approval or disapproval.
- ◆ The patient will be notified in writing if this request is not approved.

PHP Pharmacy Unit 3601 SW Murray Blvd., Suite 10-C Beaverton, OR 97005	fax to: 503-574-8646 or 1-800-249-7714	questions: 503-574-7400 or 1-877-216-3644
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