OHSU Health

Medication Exception/Prior Authorization Request Form

Fax this form and supporting chart notes to (503) 346-8351

Patient Information		
Last Name:	**First Name:**	
ID#:	**Phone #:**	
Date of Birth:		
Address:		
City:	**State:**	**Zip:**

Prescriber Information		
Last Name:	**First Name:**	
NPI:	**Phone #:**	**Fax #:**
Address:		
City:	**State:**	**Zip:**
Contact Person:		

Medication Information		
Medication Name:	**Strength:**	
Directions:	**Day Supply:**	
Is this a new medication: ☐ **Yes** ☐ **No**	**Date First Started:**	**Expected Length of Therapy:**
Diagnosis:	**ICD-10 Code:**	

Previous Medication Therapy		
Name:	**Length of Therapy:**	**Reason for Discontinue:**
Name:	**Length of Therapy:**	**Reason for Discontinue:**
Name:	**Length of Therapy:**	**Reason for Discontinue:**

Medical Justification for Requested Medication (include chart notes and supporting labs): Please provide all relevant clinical documentation to support use of this medication.

_____
_____
_____
_____
_____
_____
_____

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that an urgent review is needed to avoid seriously jeopardizing the patient's health or ability to regain maximum function.

I attest that the medication requested is medically necessary for this patient and that the information provided is accurate and true.

Prescriber Signature: _____ **Date:** _____

Confidentiality Notice: The documents accompanying this transmission contain confidential information that is legally privileged. If you are not the intended recipient, please immediately notify the sender and dispose of these documents.

For questions, contact OHSU PBM Services at 844-827-6572