



Medicaid Pharmacy Prior Authorization Request

Phone: 541-762-9090

Fax: 541-302-8052

Medically Urgent
(per Prescriber)

Instructions for Completion:

- Please print clearly.
- Complete all boxes marked with * - requests with incomplete * areas will be returned without processing.
- Attach clinical notes, lab results, imaging results, etc., to support request.

*Date	*Office Contact Person	*Phone #	*Fax #		
*Member ID#		*Member Name		*DOB	
*Prescriber/Provider Name					<input type="checkbox"/> Workers Comp <input type="checkbox"/> Accident/ Injury Related <input type="checkbox"/> SNF
Other Insurance ID#	Effective Date	Carrier	Group	Subscriber	

Medicaid Pharmacy Request (Oral, Topical, Self-injectable)

Pharmacy	Pharmacy Location	Phone	Fax
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*Dx codes pertinent to this request	Code Description
1.	
2.	
3.	
4.	
Comorbidity relating to the request	

*Medication Name	*Strength	*Quantity	Dosage Form	Retro?
1.				Y <input type="checkbox"/> N <input type="checkbox"/>
Comment:				
2.				Y <input type="checkbox"/> N <input type="checkbox"/>
Comment:				

An approval is not a guarantee of payment. Benefit eligibility must be in effect at the time services are rendered and all plan provisions will apply.

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