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			☐Workers Comp ☐Accident/ Injury Related ☐SNF
Other Insurance ID#	Effective Date	Carrier / Group / Subscriber	

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

Pharmacy	Pharmacy Location	Phone	Fax

*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 ☐N ☐
Comment:				
2.				Y ☐N ☐
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.

Revised 09/26/2014