HEALTH SYSTEMS DIVISION
Medicaid Programs

Oregon Health Authority

Prior Authorization Request for Medications and Oral Nutritional Supplements

Fax to: **Oregon Pharmacy Call Center**
888-346-0178 (fax); 888-202-2126 (phone)

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Instructions: Complete all fields marked with an asterisk (*), if applicable.

I – Request information

Requesting provider's name* ____________ NPI* ____________

Contact name ____________ Contact phone ____________

Contact fax ____________

Type of PA request* *(assignment code - check appropriate box):*

☐ Pharmacy ☐ Oral nutritional supplements ☐ Physician-administered drug

☐ Other *(please specify):* ____________

Client ID* ____________ Client name *(Last, First MI)*: ____________

Date of request ____________ Client date of birth* ____________

Processing timeframe *(select one):* ☐ Routine ☐ Urgent *(72 hours)* ☐ Immediate *(24 hours)*

Supporting justification for urgent/immediate processing:

____

II – Service information

Estimated length of treatment*: If neither box is checked, OHA will approve the maximum allowed.

☐ Maximum allowed by criteria

☐ Limited duration (please specify end date below)

Start date* ____________ End date ____________

Primary diagnosis ____________ Primary diagnosis code* ____________

Frequency ____________

Other pertinent diagnosis *(for prescriptions and oral nutritional supplements, list all applicable diagnosis codes or contributing factors causing or exacerbating a funded condition, including any relevant comorbid conditions or impacts on growth, learning or development)*:

____

III – Drug/product Information

Name ____________ *Strength ____________ Quantity ____________

*NDC ____________

Participating pharmacy:

Name ____________ Phone number ____________ Date ____________

IV – Line item information – *Required for oral nutritional supplements*

Line Item	Procedure Code	Modifier	Description	Units	From	To	Total Dollars
1							
2							
3							
4							
5							
			Total Units			**Total Dollars**	

V – Patient questionnaire – *Complete for oral nutritional supplements only*

Is the patient fed via G-tube? ☐ Yes ☐ No

Is the patient currently on oral nutritional supplements? ☐ Yes ☐ No

- If Yes, date product started: _____
- How is it supplied *(e.g., self-pay, friends/family supply)*?

Does the patient have failure to thrive (FTT)? ☐ Yes ☐ No

Does the patient have a long history *(more than one year)* of malnutrition and cachexia? ☐ Yes ☐ No

Does the patient reside in a long-term care facility or chronic home care facility? ☐ Yes ☐ No

- If Yes, list name of residence:

Does the patient have:

- Increased metabolic need from severe trauma *(e.g., severe burn, major fracture)*? ☐ Yes ☐ No
- Malabsorption difficulties (*e.g., Crohn's disease, cystic fibrosis, short gut syndrome, bowel resection/removal, gastric bypass, renal dialysis, dysphagia, achalasia)*? ☐ Yes ☐ No
- A diagnosis that requires additional calories and/or protein intake *(e.g., cancer, AIDS, pulmonary insufficiency, MS, ALS, Parkinson's, cerebral palsy, Alzheimer's)*? ☐ Yes ☐ No
- If Yes, list the diagnosis code(s):

Date of last MD assessment for continued use of supplements:

Date of Registered Dietician visit indicating inadequate intake with regular, liquefied or pureed foods:

Serum protein level: ______________ Date taken: ______________

Albumin level: ______________ Date taken: ______________

Current weight: ______________ Normal weight: ______________

Section VI – *Complete for Citizenship Waived Medical (CWM) prescriptions only*

Is the drug prescribed in conjunction with a behavioral health crisis visit (e.g., CPT codes 90839 & 90840)? If Yes, visit date: ☐ Yes ☐ No

Is the drug needed to help the patient tolerate or complete cancer therapy? ☐ Yes ☐ No

Is the drug an immunosuppressant for a kidney transplant? ☐ Yes ☐ No

Written justification and attachments:

Requesting physician's signature:

______________________________ ______________

Signature Date