

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 ____ / ____ / ____

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

Supporting justification for urgent/immediate processing:

II – Service information

Estimated length of treatment _____ Frequency _____

Primary diagnosis _____ Primary diagnosis code* _____

Other pertinent diagnosis (*for prescriptions and oral nutritional supplements, list all applicable diagnosis codes or contributing factors, including any relevant comorbid conditions*):

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? Yes No

– 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 bone fracture*)? Yes No

– Malabsorption difficulties (*e.g., Crohn's disease, cystic fibrosis, bowel resection/removal, short gut syndrome, 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 assessment indicating adequate intake is not obtainable through regular, liquefied or pureed foods: _____

Serum protein level: _____

Date taken: _____

Albumin level: _____

Date taken: _____

Current weight: _____

Normal weight: _____

Written justification and attachments:

Requesting physician's signature:

Signature _____

Date _____