Oregon Health Plan
Prior Authorization Request for Medications and Oral Nutritional Supplements

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

Confidentiality Notice:
The information contained in this Prior Authorization Request is confidential and legally privileged. It is intended only for use of the recipient(s) named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regards to the contents of this fax document- except its direct delivery to the intended recipient - is strictly prohibited. If you have received this Prior Authorization Request in error, please notify the sender immediately and destroy all copies of this request along with its contents and delete from your system, if applicable.

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

I Requesting Provider

Name* _____ NPI* _____

Contact name _____ Contact phone _____

Contact fax _____

Processing time frame: ☐ Routine ☐ Urgent ☐ Immediate

Supporting justification for urgent/immediate processing:

_____

II PA Request* - Assignment Code *(check appropriate box)*

☐ Pharmacy ☐ Oral Nutritional Supplements ☐ Physician-administered drug

☐ Other: _____

III Client Information

Client ID* _____ DOB _____

Last name* _____ First name MI* _____

IV 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):

_____

V Drug/Product Information

Name* _____ Strength* _____

Quantity* _____ NDC* _____

Participating pharmacy:

Name _____ Phone number _____ Date _____

VI Date Information

Date of request* _____ Expected service begin date* _____

Expected service end date* _____

VII Code and Cost Information – *Required for oral nutritional supplements*

Line Item	Procedure Code	Modifier	Description	Units	U&C	MSRP	Total Dollars
1							
2							
3							
4							
5							
			Total Units	$ 0.00			$ 0.00

VIII Patient Questionnaire – *Complete for oral nutritional supplements only*

Question	***Yes***	***No***
Is the patient fed via G-tube?	☐	☐
Is the patient currently on oral nutritional supplements? - If Yes, date product started: - How is it supplied (*e.g.*, self-pay, friends/family supply)?	☐	☐
Does the patient have Failure to Thrive (FTT)?	☐	☐
Does the patient have a long history (more than one year) of malnutrition and cachexia?	☐	☐
Does the patient reside in a: - Long-term care facility? - Chronic home care facility? - If Yes, list name of residence:	☐ ☐	☐ ☐
Does the patient have: - Increased metabolic need from severe trauma (*e.g.*, severe burn, major bone fracture)? - Malabsorption difficulties (*e.g.*, Crohn's Disease, cystic fibrosis, bowel resection/removal, Short Gut Syndrome, gastric bypass, renal dialysis, dysphagia, achalasia)? - A diagnosis that requires additional calories and/or protein intake (*e.g.*, cancer, AIDS, pulmonary insufficiency, MS, ALS, Parkinson's, cerebral palsy, Alzheimer's)?	☐ ☐ ☐	☐ ☐ ☐

Date of last MD assessment for continued use of supplements:

Date of Registered Dietician assessment indicating adequate intake is not obtainable through regular or liquefied pureed foods:

- Serum protein level: Date taken:
- Albumin level: Date taken:
- Current weight: Normal weight:

Written justification and attachments:

Requesting Physician's signature: _____