Medication Exception/Prior Authorization Request Form

Fax this form and supporting chart notes to (503) 346-8351

Patient Information		
Last Name:	**First Name:**	
ID#:	**Date of Birth:**	
Phone #:		
Address:		
City:	**State:**	**Zip:**

Prescriber Information		
Last Name:	**First Name:**	
NPI #:	**Specialty:**	
Phone #:	**Prescriber Fax #:**	
Address:		
City:	**State:**	**Zip:**
Contact Person:	**Phone #:**	**Fax #:**

Medication Information		
Medication Name:	**Strength:**	
Directions:	**Day Supply:**	
Is this a new medication: ☐ **Yes** ☐ **No**	**Date First Started:**	**Expected Length of Therapy:**
Diagnosis:	**ICD-10 Code:**	

Previous Medication Therapy		
Name:	**Length of Therapy:**	**Reason for Discontinue:**
Name:	**Length of Therapy:**	**Reason for Discontinue:**
Name:	**Length of Therapy:**	**Reason for Discontinue:**

Medical Justification for Requested Medication (include chart notes and supporting labs): Please provide all relevant clinical documentation to support use of this medication.

_____
_____
_____
_____
_____
_____
_____

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that an urgent review is needed to avoid seriously jeopardizing the patient's health or ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the requested medication.

I attest that the medication requested is medically necessary for this patient and that the information provided is accurate and true.

Prescriber Signature: _____ **Date:** _____

For questions, contact OHSU PBM Services at 1-833-631-7991