Prescription Drug Prior Authorization Request Form

Providence Health Plan

Providence Health Assurance

This form is to be completed by the prescribing provider and staff. Please complete in full to avoid a processing delay. Fax completed forms.

Patient Information		
Patient's Name (Last, First, MI):		
Member ID:	Date of Birth:	
Requesting Provider Information		
Requesting Physician/Provider's Name:	Specialty:	
NPI:	Tax ID No:	
Address:		
Phone:	Fax:	
Contact Name:	Phone:	Fax:
Pharmacy Name (For Prescription Drugs):	Phone:	Fax:
Medical Drug Information (if applicable, patient will receive medication in clinic)		
Site of Care Location:	Start Date:	
Address:		
Phone:	NPI:	Tax ID:
Drug Information		
Requested Drug Name/Strength:	ICD-10:	
Quantity:	Directions:	Length of Therapy:
List of Drugs Previously Tried (Formularies are available at https://www.providencehealthplan.com/members/pharmacy-resources)		
Drug Name:	Dosage:	

Provide the medical rationale for requested drug (include chart notes and supporting labs) and why a formulary alternative is not acceptable

_____

_____

☐ Urgent Request

Requesting Provider's Signature: _____ Date:_____

STRICT CONFIDENTIALITY IS MAINTAINED FOR ALL MEDICAL INFORMATION AND REQUESTS.

Any additional information needed will be requested via telephone or fax. Your office will be notified by fax of the decision.

Providence Health Plans ATTN: Pharmacy Services PO Box 3125 Portland, OR 97208	Fax 503-574-8646 or 800-249-7714	Questions Please Call 503-574-7400 or 877-216-3644	**ATTENTION:** **For prescriptions obtained at a pharmacy, electronic PA can be submitted via either CoverMyMeds or SureScripts**