

**Prior Authorization Request
for Prescriptions & Oral Nutritional Supplements**

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

Confidentiality Notice:

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

I Requesting Provider

* Name _____ * NPI _____
 Contact Name _____ Contact Phone _____ - _____ - _____
 Contact Fax _____ - _____ - _____ Processing Time Frame: Routine
 Supporting Justification for Urgent/Immediate Processing: Urgent
 _____ Immediate

II PA Request - Assignment Code (check appropriate box)

* Pharmacy Home EPIV Other _____

III Client Information

* Client ID _____ DOB _____ / _____ / _____
 * Last Name _____ * First Name, MI _____

IV Service Information

Estimated length of treatment _____ Frequency _____
 Primary diagnosis _____ * Primary ICD-9 diagnosis code _____
 Other pertinent diagnosis
 (For prescriptions and oral nutritional supplements, list all applicable ICD-9 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 EPIV and oral nutritional supplements

Line Item	Procedure Code	Modifier	Description	Units	U&C	MSRP	Total Dollars
1							
2							
3							
4							
5							
			Total Units	0			\$0

VIII Patient Questionnaire – Complete for oral nutritional supplements only

Question	Yes	No
Is the patient fed via G-tube?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient currently on oral nutritional supplements? - If Yes, date product started: _____ - How is it supplied (e.g., self-pay, friends/family supply, etc)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have Failure to Thrive (FTT)?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have a long history (more than one year) of malnutrition and cachexia?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient reside in a: - Long-term care facility? - Chronic home care facility? - If Yes, list name of residence: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
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)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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: _____