Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147 • TTY: 877-769-7400

Medication Authorization Form

• For questions call: 541-269-7400 • Fax Completed Form and Records to 541-269-7147•
****PLEASE NOTE: INCOMPLETE FORMS WILL DELAY THE AUTHORIZATION PROCESS****

Member's primary health insurance: Advanced Health OHP ☐ Dual Eligible - has Medicare and Advanced Health OHP ☐

Member Name: _____

Plan ID #: _____ **(Required)**

Member's Date of Birth: ____/____/____ **(Required)**

Requesting Provider: _____ PCP ☐ Specialist ☐ Other ☐

Provider's Phone Number: _____Provider's Fax Number: _____

ICD-10 Code: _____ **(Required)**

Other Related ICD-10 Codes: _____

Drug Requested: _____ Dosage: _____

Duration of Therapy: _____ Pharmacy: _____

Phone: _____ Fax: _____

Has medication on the Formulary been tried for this condition? (Check one): ☐ Yes ☐ No

Clinical Rationale for Non-Formulary Medication:

Signature of Requesting Physician: _____

Date: ____/____/____

Disclaimer: Prior Authorization does not guarantee payment. Payment depends on patient eligibility on date of service, contract terms, and compliance with rules, regulations and policies of DMAP, Medicare and Advanced Health as applicable.