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 Name: _____

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

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

Requesting Provider: _____ PCP ☐ Specialist ☐ Other ☐

Requesting Provider NPI#: _____

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

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

Other Related ICD-10 Codes: _____

Drug Requested: _____ Dosage: _____

Duration of Therapy: _____ Pharmacy: _____

Pharmacy Phone: _____ Pharmacy 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.