

This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000, for the following prescription:

① **Dispensing pharmacy's contact information:**

NPI: \_\_\_\_\_ Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

② **Prescription information:**

Rx number: \_\_\_\_\_ Drug name: \_\_\_\_\_ Quantity/day supply: \_\_\_\_\_  
 NDC: \_\_\_\_\_ Date dispensed: \_\_\_\_\_ Billed amount: \_\_\_\_\_

③ **Client information:**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Client ID: \_\_\_\_\_

The client agrees to pay for this prescription, for one of the reasons listed below. **Please complete ONE of these sections:**

**I. Medication is not covered by the Oregon Health Plan**

- Pharmacy representative:
  - I have confirmed that the Oregon Health Plan (OHP) does not cover this prescription.
  - I have confirmed that the billed amount listed above is no greater than our usual and customary rate.
- Client:
  - I understand that because OHP does not cover this prescription, the Oregon Health Authority (OHA) or my coordinated care organization (CCO) cannot pay for it.
  - I understand that if I get this prescription, I agree to pay the costs and will not be paid back.
  - I have read the back of this form and understand my other options. I still choose to get this prescription.

**II. Medication requires prior approval**

- Pharmacy representative:
  - I have confirmed that OHP will only cover this prescription if approved by OHA or the CCO.
  - I have confirmed that this prescription does not qualify for an emergency temporary supply.
  - I have confirmed that the billed amount listed above is no greater than our usual and customary rate.
  - I understand the pharmacy must refund the billed amount to the client if OHP pays for this prescription later.
- Client:
  - I understand that OHA or my CCO has to approve this prescription before OHP can cover it.
  - I understand that if I get this prescription now, I agree to pay the costs.
  - I understand that if OHA or my CCO approves the prescription, I can ask the pharmacy to bill OHP.
  - I understand that the pharmacy will repay me only if OHP pays for the prescription.
  - I have read the back of this form and understand my other options. I still choose to get this prescription.

**III. Client wants to pay for a covered medication**

- Pharmacy representative:
  - I have confirmed that OHP will cover this prescription, but the client does not want it billed to OHP.
- Client:
  - I understand that OHP can cover this prescription. I do not want this prescription billed to OHP.
  - I understand that if I get this prescription, I will pay the costs and will not be paid back.
  - I understand that I am paying the pharmacy's usual and customary charge, which is higher than what OHP would pay.
  - I have read the back of this form and understand my other options. I still choose to get this prescription.

**Both the client and pharmacy representative must read and sign the back of this form, and keep a copy for their records.** Pharmacies must keep completed forms on file for at least five years.

**Attention OHP client – Read this information carefully before you sign.**

Before you sign, make sure that the Oregon Health Plan (OHP) does not cover the prescription. If OHP does not cover the prescription, the Oregon Health Authority (OHA) or your coordinated care organization (CCO) cannot pay for it. Here are some things you can do:

**Make sure the service is not covered**

If the prescription must be approved by OHA or your CCO, you will get a Notice of Action – Benefit Denial (NOABD) if the prescription cannot be approved. This Notice explains why the prescription was not approved. It also explains how you can ask OHA or your CCO to change the decision by asking for an Appeal or Hearing.

- If you did not receive a Notice of Action, ask OHA or your CCO to send you one.
- Read the Notice of Action carefully. It will also give you information about how to ask for an Appeal or Hearing.

**If you also have Medicare, you may have other Appeal rights.** Call 800-Medicare (800-633-4227) or TTY 711.

**If you have Medicare, see if your Medicare Part D plan covers the prescription**

If you need help with Medicare Part D, call the Oregon’s Medicare Medication Assistance (MMA) line at 877-585-0007.

**Check to see if there are other ways to get the prescription**

- Ask your provider if they have tried all other covered medications that could treat your condition.
- There may be service organizations, free clinics, county health departments, prescription assistance programs, and manufacturer’s coupons or discounts that might help you pay for it.
- Will your OHP benefits, or any other health insurance, change soon? If so, try to find out if they will cover the prescription.

**Questions?**

- Call your CCO’s Customer Service department, or
- Call the OHP Client Services Unit at 800-699-9075, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP and paying for services.

**Attention Provider – Relevant Oregon Administrative Rules (OARs)**

Requirements of this Agreement are in OAR 410-120-1280, Billing; 410-120-1360, Requirements for Financial, Clinical and Other Records; and 410-141-3540, Member Protections. These rules can be found online at <https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87>.

**Signatures**

\_\_\_\_\_  
 Pharmacy representative’s signature Date  
 Pharmacy representative’s name: \_\_\_\_\_

\_\_\_\_\_  
 Client (or representative’s) signature – *Representative must have proof of legal authority to sign for this client* Date  
*If signed by the client’s representative, print their name here:* \_\_\_\_\_

**You can get this form in another language, large print, or another way that is best for you. Call 800-699-9075 (TTY 711).**