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 Opt. 2 • Fax Completed Form and Records to 541-269-7147•

****PLEASE NOTE: INCOMPLETE FORMS WILL BE CANCELLED AS INVALID AUTHORIZATION****

****WE DO NOT WORK WITH COVER MY MEDS****

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

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

Requesting Provider: _____ PCP ☐ Specialist ☐ Other ☐

Requesting Provider NPI#: _____

Contact Name: _____ Contact Phone#: _____Fax #: _____

ICD-10 Code: _____ **(Required)** Other Related ICD-10 Codes: _____

Drug Requested: _____Dosage: _____

Length of Treatment (in months – 12 max): _____

Pharmacy: _____ Pharmacy Phone: _____Pharmacy Fax: _____

Current Chart Note within past 12 months included. (Check one): ☐ Yes ☐ No

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

PDMP has been checked (Required for controlled substances): ☐ Yes ☐ No

Clinical Rationale for Non-Formulary Medication:

Prepared By: _____

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.

(Rev 9.2023)