UMPQUA HEALTH ALLIANCE

Prior Authorization Request Form For Prescription Drugs

Fax this completed form to (541) 677-5881 Phone: (541) 672-1685

SUPPORTING DOCUMENTATION IS REQUIRED TO BE SUBMITTED WITH ALL REQUESTS

Fill in all fields with an * - Incomplete Requests will be returned without processing

Date of Request: _____/_____/_____

MEMBER INFORMATION		
*Member Name:	*Member ID:	*Member DOB:
PROVIDER INFORMATION		
*Provider Name:	MD ☐ DO ☐ FNP ☐ NP ☐ PA ☐	*NPI:
*Office Contact Person:	*Phone #:	*Fax #:

MEDICATION INFORMATION (One medication request per form)		
*Drug name, strength and form:	*Directions:	*Qty per Day:
*Expected Length of Treatment:		

DIAGNOSIS INFORMATION
*Diagnosis Code(s):

MEDICATION HISTORY FOR THIS DIAGNOSIS
A. Is the member currently being treated with this medication? ☐Yes; how long? (go to B) ☐No (go to E)
B. Is this a renewal request from a prior approval? ☐Yes (go to C) ☐No (go to E)
C. ☐Retro only - Date _____/_____/_____ ☐ Retro + ongoing treatment – Date _____/_____/_____
D. Has the strength, dosage, or quantity required per day increased or decreased? ☐Yes (go to E) ☐No
E. Please indicate prior treatment and outcomes in the table below:

Medication Name (strength and dosage)	Dates of Treatment	Reason for Discontinuation
1.		
2.		
3.		
4.		

Statement of Medical Necessity:

*Please include current chart notes with requests, and lab reports when appropriate