Prior Authorization Request Form for Professionally Administered Drugs (PAD)

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: _____/_____/________ * Start Date: _____/_____/________ * End Date: _____/_____/________

MEMBER INFORMATION		
*Member Name:	*Member ID #:	*Date of Birth:
REQUESTING PROVIDER INFORMATION		
*Provider Name: MD ☐ DO ☐ FNP ☐ NP ☐ PA ☐		*NPI #:
*Office Contact Person:	*Office Fax:	*Office Phone:
*Address:		
DELIVERING PROVIDER INFORMATION (Facility and/or doctor administering drug)		
*Provider Name: MD ☐ DO ☐ FNP ☐ NP ☐ PA ☐		*NPI #:
*Office Contact Person:	*Office Fax:	*Office Phone:
*Address:		
DIAGNOSIS INFORMATION		
*Diagnosis Code(s):		

***PROFESSIONALLY ADMINISTERED DRUGS AND SERVICES**

*HCPCS (CPT Code)	*Name	*Strength	*Directions	*Quantity/Total Units	*NDC

Inpatient ☐	Outpatient ☐

HISTORY FOR THIS DIAGNOSIS

A. Is the member currently being treated with this drug? ☐ 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

Treatment	Dates of Treatment	Reason for Discontinuation
1.		
2.		
3.		
4.		

Statement of Medical Necessity:

PAYMENT FOR ALL SERVICES IS SUBJECT TO CONFIRMATION that the beneficiary is eligible to receive the services as a covered benefit, the applicability of other sources for payment, UHA's Clinical Engagement and other policies and procedures, the terms of its contract with the state of Oregon, and all applicable laws, each as in effect or determined at the time each service is performed. Umpqua Health Alliance operates a Medicaid plan under the Oregon Health Plan. If you are a nonparticipating provider, payment is made at the rate set out in the relevant Oregon Administrative Rule. Generally, those rules can be found at OAR Chapter 410.