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 **List all applicable diagnosis codes contributing to the primary condition.**		
*Primary Diagnosis Code(s):		
Comorbid 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

1. Is the member under age 21? ☐Yes ☐No
2. If yes, will treating the condition enhance the patient's ability to grow, develop, or participate in school? ☐Yes☐No
   ***Provide documentation to support this answer.

Additional Notes:

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