



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 • Fax Completed Form and Records to 541-269-7147•
****PLEASE NOTE: INCOMPLETE FORMS WILL BE CANCELLED AS INVALID AUTHORIZATION****

Member Name: _____

Plan ID #: _____ (Required)

Member's Date of Birth: ___/___/___ (Required)

Requesting Provider: _____ PCP Specialist Other

Requesting Provider NPI#: _____

Provider's Phone Number: _____ Provider's Fax Number: _____

ICD-10 Code: _____ (Required)

Other Related ICD-10 Codes: _____

Drug Requested: _____ Dosage: _____

Duration of Therapy: _____ Pharmacy: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

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:

Signature of Requesting Physician: _____

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.