Oregon Health Plan Prior Authorization Request Form for Prescription Drugs

☐ **Medically Urgent (per prescriber)**

FAX this completed form to (833) 645-2735 | Phone: (833) 913-1004

OR Mail requests to: Trillium Community Health Plan PA Department | P.O. Box 11740 | Eugene, OR 97440-3940

Complete all boxes marked with a * - Requests with incomplete * areas will be returned without processing.

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
*Prescriber name (print):	*Member name:
*Office contact name:	*Identification number:
Group name:	Group number:
*Fax:	*Date of Birth:
*Phone:	Medication allergies:

III. PHARMACY INFORMATION (If known)	
Pharmacy name:	Pharmacy Fax:

IV. DRUG INFORMATION (One drug request per form)			
*Drug name and strength:	Dosage form:	Dosage Interval (sig)	*Qty per Day:
*Diagnosis code:			
Expected length of therapy:			

Medication History for this Diagnosis

A. Is member currently treated on this medication?

❑ yes; How Long?_____[go to item B] ❑no [skip items B & C; go to item D]

B1. Is this request for continuation of a previous approval? **B2.** ❑ Retro fill only Date ____/____/_____

❑yes [go to item C] ❑no [skip item C; go to item D] ❑ Retro fill + ongoing Date ____/____/_____

C. Has strength, dosage, or quantity required per day increased or decreased?

❑ yes [go to item D] ❑no [skip item D; indicate rationale for continuation in Section IV and submit form]

D. Please indicate previous treatment and outcomes below.

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1		
2		
3		

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. The Trillium Community Health Plan Formulary is available on the Trillium website at https://www.trilliumohp.com/providers/helpful-links.html.

V. RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION (Required for all Prior Authorizations)

☐ Check this box if you want Trillium Community Health Plan to consider a comorbid condition. (If checked, list the comorbid condition):

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Please include current chart notes and lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)