



Tuality Health Alliance

OREGON HEALTH PLAN

Physician Drug Prior Authorization Form

FAX TO:
503-681-1823

QUESTIONS:
503-681-1465

- The formulary drug list is available at: www.tualityhealthalliance.org
- The physician should FAX this form to the above listed FAX number.

Patients Name: _____ Member Id # _____

Physician Name: _____ Physician Phone #: _____

****PLEASE INCLUDE CHART NOTES****
REQUEST WILL NOT BE ACCEPTED WITHOUT CHART NOTES

ICD-9 Code (Mandatory): _____

Drug Name: _____ Dose: _____


Frequency: _____


Is patient currently receiving the drug? Yes No Samples

- List other THA formulary medication(s) the member has tried & failed:

Medication(s)

How it failed (Mandatory)

_____  _____

_____  _____

****Request will not be accepted without physician's signature****

- Physician's Signature: _____ Date: _____

STRICT CONFIDENTIALITY IS MAINTAINED FOR ALL MEDICAL INFORMATION AND REQUESTS.
Telephone/fax contact will occur if more information is needed. The physician office will be notified by fax of approval or disapproval. The patient will be notified in writing if this request is not approved.