eocco
EASTERN OREGON
COORDINATED CARE
ORGANIZATION

Prescription drug prior authorization request form

This prior authorization request form should be filled out by the provider. Before completing this form, please confirm the patient's benefits and eligibility. A prior authorization list can be found at OneHealthPort.com under Moda Health or by calling 888-474-8539. Benefits for services received are subject to eligibility and plan terms and conditions that are in place at the time services are provided.

Is this request urgent? Defined as: A delay of service could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function. –Or– In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the disputed care or treatment. If this request is urgent and meets the definition as indicated above, please check this box.

☐ **Urgent request**

Date (mm/dd/yyyy)	Is this request: ☐ New ☐ Authorization Extension ☐ Providing additional information	If you already have an authorization number, list it here:

Section 1 › Patient information

Subscriber last name		First		M.I.
Gender ☐ Male ☐ Female	Date of birth (mm/dd/yyyy)		Height	Weight
Member ID	Group no.		Allergies	
Secondary insurer member ID	Secondary insurer group no.			

Section 2 › Prescriber/Provider information

You are: ☐ Requesting provider ☐ Servicing provider ☐ Specialty		If you are a specialty provider, list your specialty here:	
Provider name			
Tax ID no.	NPI		DEA no. (if required)
Provider address			Phone
City	State	ZIP code	Fax
Who should we contact if we require more information?		Phone	Fax

Section 3 › Patient's PCP information (if applicable)

Name of PCP	
Phone	Fax

Section 4 > Medication/Medical and Dispensing information

Medication name				
Dose/strength	Frequency	Quantity	Length of therapy	Number of refills
☐ New therapy ☐ Renewal therapy	If renewal, date therapy initiated (mm/dd/yyyy)			
Route of administration ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other (please specify)				
Administered ☐ Doctor's office ☐ Dialysis center ☐ Home health ☐ By patient ☐ Other (please specify)				

List of previous drugs tried

Drug name	Dosage
Drug name	Dosage
Drug name	Dosage
Drug name	Dosage

Provide the medical rationale for requested drug (include chart notes and supporting labs) and why a formulary alternative is not acceptable.

Provide all ICD-9 or ICD-10 codes and their descriptions, if available; this will help us process your request.

Codes are ☐ ICD-9 ☐ ICD-10	Diagnosis
Primary	
Second	
Third	

Submit the following clinical information with this form as appropriate for this request:

- History & physical
- Lab/radiology/testing results
- Current symptoms and functional impairments
- Treatment history
- Any other information such as chart notes that support medical necessity for the request

Ready to submit? Mail this form to EOCCO, P.O. Box 40384, Portland, OR 97240-0384 or fax to 800-207-8235, Attn: Pharmacy Services

Questions? Call EOCCO Pharmacy Customer Service at 888-474-8539.