PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request	Review Timeframe Expediated ☐ Standard ☐

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name	Last Name	MI	Phone Number

Address	City	State	Zip Code

Date of Birth	Male Female	Height (in/cm)	Weight (lb/kg)

Patient's Authorized Representative (if applicable):	Authorized Rep. Phone	Allergies

Prescriber Information

First Name	Last Name	Specialty

Address	City	State	Zip Code

Office Contact	Office Phone

NPI	Office Fax (HIPPA Compliant area)

Email Address

Medication Information

Medication Name	Dosage/Strength

☐ New Therapy ☐ Continuing Therapy ☐ Step Therapy Exception Request

If Continuing, Date Therapy Initiated:	Duration of Therapy (specific dates):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV Other:_____

Administration Location:				
Physician's Office ☐		Patient's Home ☐		Long Term Care ☐
Ambulatory Infusion Center ☐		Home Care Agency ☐		Other (explain):_____
		Outpatient Hospital Care ☐		_____

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name	Oscar ID#

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? complete below if Yes	**Yes** ☐	**No** ☐

Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response to Therapy or Reason for discontinuance

2. List Diagnoses:	**ICD10:**

3. Clinical documentation is <u>required</u> for review - Please provide all relevant clinical information to support a prior authorization review.

Please provide clinical documentation, including chart notes, lab results, medication history with dates and/or justification for initial or ongoing therapy and any other documentation pertinent to the requested medication and patient's condition. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage or required under state and federal laws. Feel free to also include a clinical rationale for the requested medication in the space below.	Attachment ☐

Clinical Rationale:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature	Date

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