Oregon CAREAssist
CLAIMS AUTHORIZATION REQUEST FORM
Version 8.1

Provider Services: 888-311-7632
Fax Form to: 800-848-4241
or 510-587-2799

*PLEASE REVIEW REQUEST FOR ACCURACY AND COMPLETE ALL APPROPRIATE FIELDS! **To be completed by the Pharmacy***

PHARMACY INFORMATION

NPI: _____

CONTACT PERSON: _____
STAMP or **WRITE** Pharmacy Name, Phone & Fax:

PHONE: ( ) _____

FAX: ( ) _____

CLIENT INFORMATION
(Print Clearly)

_____
Last Name First Name

I.D.: _____

D.O. B. _____ / _____ / _____

		Copay or Cash Price	Requested QTY	Days Supply	OCC	Prescription Date*
RX#1	NDC : _____-_____-_____	$: _____		_____		_____
RX#2	NDC : _____-_____-_____	$: _____		_____		_____
RX#3	NDC : _____-_____-_____	$: _____		_____		_____
RX#4	NDC : _____-_____-_____	$: _____		_____		_____
RX#5	NDC : _____-_____-_____	$: _____		_____		_____
RX#6	NDC : _____-_____-_____	$: _____		_____		_____
RX#7	NDC : _____-_____-_____	$: _____		_____		_____
RX#8	NDC : _____-_____-_____	$: _____		_____		_____

MUST CHECK ALL THAT APPLY!
PROOF OF BILLING MUST ACCOMPANY THIS REQUEST

Program Limits
- ☐ Max $ per prescription override
- ☐ Claim over ___ days

Plan Limit
- ☐ CII or CIII Max* **original Rx required*
- ☐ Maximum fills per year
- ☐ ARV Daily QTY Max***Submit w/Treatment Exception Request (TER) form*
- ☐ Day supply ___ with copay
- ☐ Day supply less than minimum required
- ☐ Lost med fill
- ☐ Vacation Supply

Clinical Limits
- ☐ ARV Duplicate Therapy***Submit w/Treatment Exception Request (TER) form*
- ☐ Code 1 or Diagnosis Required
- ☐ Step Therapy Override
- ☐ Supplemental Form Required
- ☐ Medicare Exclusion
- ☐ OTC Drug

Other
- ☐ DAW____
- ☐ Insurance/Plan Denial** *Must provide detailed denial information from the primacy insurance.*

Notes/Explanation: