TREATMENT EXCEPTION REQUEST

OREGON CAREAssist

FOR PROVIDER USE ONLY (PLEASE PRINT CLEARLY)

Phone: 888-311-7632 Fax: 800-848-4241

***PATIENT INFORMATION:**

LAST NAME FIRST NAME

Patient's ADAP ID Date of Birth

Most Recent Viral Load test/date:_____

Most Recent CD4 Count/date:_____

Current Weight:_____Current Height:_____

Previous Weight:_____Date:_____

***DIAGNOSIS DESCRIPTION:**

***MEDICAL JUSTIFICATION (extra pages may be attached if necessary, please be specific):**

***PHARMACY INFORMATION:**

Pharmacy Name NABP#

Phone Number Fax Number

***PHYSICIAN INFORMATION:**

Last Name First Name

Phone Number Fax Number

DEA Number E-Mail address

Address City Zip Code

*

Signature of pharmacist or physician Date

DRUGS REQUESTED (ADAP FORMULARY MEDICATIONS ONLY):

GENERIC NAME	NDC - 11	DIRECTIONS	QUANTITY

Ramsell USE ONLY

REQUEST: ☐APPROVED AS REQUESTED ☐APPROVED AS MODIFIED ☐DENIED

COMMENTS:

AUTHORIZATION VALID FROM: ____/____/_____ TO ___/____/_____ BY:_____DATE:_____☐

LONG TERM AUTHORIZATION ☐ PRIOR AUTHORIZATION REQUIRED FOR EACH FILL

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ADAP ELIGIBILITY. BE SURE PATIENT'S ELIGIBILITY IS CURRENT BEFORE DISPENSING DRUG.