PHARMACY SERVICES
OHP Prior Authorization (PA) Request Form

PHONE (888) 474-8539
FAX (800) 207-8235
www.odscompanies.com

DATE: ______________________ SENDER'S INITIALS: ______________________

PATIENT INFORMATION

ENROLLEE NAME: ______________________ DATE OF BIRTH: ______________

SUBSCRIBER ID #: ____

PHYSICIAN INFORMATION

NAME: ____

PHONE: ______________________ FAX: ______________________

CONTACT NAME: ____

MEDICATION INFORMATION

MEDICATION: ____

STRENGTH: ______________________ FREQUENCY: ______________

ICD-9 CODE: ____

PREVIOUS MEDICATIONS TRIED, INCLUDING DOSE AND DURATION OF TRIAL: ______________________________

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CIRCUMSTANCES FOR MEDICAL NECESSITY: ______________________________

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Updated: December, 2007

OHP Prior Authorization (PA) Request Form (continued)

ADDITIONAL QUESTIONS