TualityHealthAlliance

Drug Prior Authorization Form

Phone: 503-844-8104 **Fax: 503-681-1823**

- ✓ **THA FORMULARY IS AVAILABLE ONLINE AT – WWW.TUALITYHEALTHALLIANCE.ORG**
- ✓ **THIS REQUEST WILL NOT BE ACCEPTED WITHOUT THE PROVIDER'S SIGNATURE**
- ✓ **THIS REQUEST WILL NOT BE ACCEPTED WITHOUT CHART NOTES SHOWING THE MEDICAL NECESSITY**

MEMBER NAME:_____ **ID #:** _____

PROVIDER NAME:_____ **Phone:**_____ **Fax:**_____

Dx:_____ **ICD-10:** _____

Dx:_____ **ICD-10:** _____

Dx:_____ **ICD-10:** _____

Dx:_____ **ICD-10:** _____

Drug Name:_____

Drug Dose: _____ **Directions (Sig):** _____

List any related and/or step therapy medication(s) the patient has tried and failed

Medication	**How Medication Failed**

Prescriber Signature:_____ **Date:**_____

PROVIDER AND PHARMACY (IF APPLICABLE) WILL BE NOTIFIED OF AUTHORIZATION DETERMINATION VIA FAX

PATIENT WILL BE NOTIFIED OF DETERMINATION IN WRITING ONLY IF REQUEST IS DENIED