Health Net Health Plan of Oregon, Inc.
Health Net Life Insurance Company

Prior Authorization / Formulary Exception Request Fax Form

FAX TO: (800) 255-9198

Form must be fully completed to avoid a processing delay. **For status of a request, call: (888) 802-7001**

Patient's Name (Last, First, MI)		Date of Birth ------------------ MM / DD / YYYY ------------------ / /
Member ID # ----------- Please print clearly and enter one digit per box ------------	Patient's Phone ----------- Please print clearly and enter one digit per box ---------- ( ) –	
Patient's Address, City, State, ZIP Code	Gender ☐ M ☐ F	Allergies
Provider's Name (Last, First, MI)	Provider Specialty	Contact Name
Provider's Address, City, State, ZIP Code		NPI #
------- Provider's Phone ----- Please print clearly and enter one digit per box ------- ( ) –	-------- Provider's Fax ------- Please print clearly and enter one digit per box -------- ( ) –	
Medication Name and Strength	Quantity	Direction for Use and Duration
Administered: ☐ Doctor's Office ☐ Dialysis Center ☐ Home Health ☐ By Patient ☐ Other (specify):		
Diagnosis	ICD Code	New Start with This Medication? ☐ Yes ☐ No If No, Date of First Dose:
Medications Previously Tried with Dates of Use		
Medical Justification and Supporting Information (attach labs and/or chart notes as appropriate)		

For Medicare members only: Please review carefully and complete each applicable subsection.

For **all requests**: Is the patient currently receiving dialysis? Yes ☐ No ☐	
For drugs considered to be **High Risk Medications (HRM)** for the elderly (i.e. drugs on the **Beers List**), is the patient continuing on this medication without adverse effects? Yes ☐ No ☐	Comment:
For **immunosuppressive** medication requests: Is it being used for a transplant? Yes ☐ No ☐	If Yes, date of transplant:
For **antiemetic** medication requests: Will the patient be on any other concurrent antiemetic therapy? Yes ☐ No ☐ Specify medication(s) & route: _______________________________________	Will this medication be used as full therapeutic replacement for intravenous antiemetic medications within 2 hours and continued for a period not to exceed 48 hours of chemotherapy? Yes ☐ No ☐
For **nutritional supplement (enteral or parenteral)** medication requests: Does the patient have a G-tube? Yes ☐ No ☐ Does the patient have a permanent dysfunction of the digestive track? Yes ☐ No ☐	

I certify that the above information is correct to the best of my knowledge.

Physician's Signature	Date
Name of provider/vendor submitting this form if other than the prescriber above	Phone #

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Mailing Address: Pharmacy Prior Authorization Department, 13221 SW 68th Parkway, Suite 200, Tigard, Oregon 97223-8328

For copies of prior authorization forms and guidelines, please call (888) 802-7001 or visit the provider portal at provider.healthnet.com.

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