OREGON OMAP PRIOR AUTHORIZATION REQUEST
FOR EXEMPTION TO ON-LINE REIMBURSEMENT DENIAL

PRESCRIBING PHYSICIAN:

NAME: _____
First Last

DEA LICENSE # _____

PHONE #: _____

FAX #: _____

OMAP PATIENT:

NAME: _____
First Last

MEDICAID ID #: _____

DATE OF BIRTH: _____ SEX _____

REQUEST DATE: _____

PARTICIPATING PHARMACY:

NAME: _____ PHONE: _____

PRIOR AUTHORIZATION REQUEST FOR: *(Please check appropriate prior authorization type)*

- ❑ Acute Anit-Ulcer Therapy
- ❑ Nasal Inhaler
- ❑ Excessive Narcotic Dose
- ❑ Accutane/Retin-A
- ❑ Lactulose
- ❑ Growth Hormones
- ❑ Oral/Nutritional Supplements
- ❑ Drugs with Cosmetic Indications
- ❑ Antihistamine
- ❑ Weight Reduction Therapy
- ❑ Anti-fungal

DRUG NAME	STRENGTH	LENGTH OF THERAPY

ICD9 DIAGNOSIS:

MEDICAL JUSTIFICATION FOR PRODUCT USE: *(Use back of form if necessary)*

_____

Doctor's Signature: _____

FIRST HEALTH SERVICES USE ONLY: ❑ *APPROVED* ❑ *DENIED*

DATE: _____/ ____ / _____

COMMENTS: _____

MAP RPh: _____ _____

NDC: _____ _____

SUBMIT REQUESTS TO:

FIRST HEALTH SERVICES
FAX: 1-800-250-6950
PHONE: 1-800-344-9180

4300 Cox Road
Glen Allen, VA 23060