
**ODS PHARMACY SERVICES**

**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**
**Phone (503) 243-3960**
**Fax (503) 948-5556**

---

**DATE:** _____

*Patient Information*

**NAME:** _____ **DOB:** _____

**MEMBER I.D.#** _____

*Physician Information*

**PHYSICIAN NAME:** _____

**PHONE & FAX NUMBER:** _____

**CONTACT NAME:** _____

*Medication Information*

**MEDICATION:** _____

**QUANTITY REQUESTED:** _____

**ICD-9 CODE:** _____

**PREVIOUS MEDICATIONS TRIED:** _____

_____

_____

***Circumstances/Reasons for Medical Necessity*:** _____

_____

_____