Instructions for Providers:

Please note that this form must be filled out completely; Include any Clinical documentation relating to the Case

1. Please list all previously tried and failed medications, including those covered by a prior plan.
2. Please list all diagnoses relevant to the medication(s) or treatment.
3. Please list (or attach) any clinical information. In accordance with state and federal laws where applicable, clinical documentation (such as chart notes and labs) may be required for review of Prior Authorization requests.

Need more info?

Phone
Non-Specialty: 855-582-2022
Specialty: 866-814-5506

Fax
Non-Specialty: 1-844-814-2258
Specialty: 1-844-814-2259

Oscar's $3 Drug List
www.hioscar.com/prescriptions/3-dollar-list

Oscar's Provider Portal
https://provider.hioscar.com/search

Oscar's Formularies (Lists of Covered Drugs)
www.hioscar.com/search-documents/drug-formularies

OSCAR PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request. **Included behind this form is the drug specific criteria for your reference only and is not required to be completed.**	Review Timeframe Expedited ◯ Standard ◯

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name	Last Name	MI

Oscar ID:	Phone:

Address	City	State	Zip Code

Date of Birth	Male ◯ Female ◯	Height (in/cm)	Weight (lb/kg)

Patient's Authorized Representative (if applicable):	Authorized Rep. Phone	Allergies

Prescriber Information

First Name:	Last Name:	Specialty:

Address:	City:	State:	Zip:

Office Contact:	Office Phone:

NPI:	Office Fax:

Medication Information

Medication Name:

◯ New Therapy ◯ Continuing Therapy ◯ Step Therapy Exception Request

If Continuing, Date Therapy Initiated:	Duration of Therapy (specific dates):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV Other: _____

Administration Location:		
Physician's Office ◯	Patient's Home ◯	Long Term Care ◯
Ambulatory Infusion Center ◯	Home Care Agency ◯	Other (explain):_____
	Outpatient Hospital Care ◯	_____

OSCAR PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? If yes, complete the following table and attach medical records	**Yes** ◯	**No** ◯

Drug Name and Dosage	Duration of Therapy (Specify Dates)	Response to therapy or reason for discontinuation

2. List Diagnoses:	**ICD10:**

3. Required Clinical Information - Please provide all relevant clinical information to support a prior authorization or step therapy review.

Please provide clinical documentation, including chart notes, lab results, medication history with dates and/or justification for initial or ongoing therapy and any other documentation pertinent to the requested medication and patient's condition. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage or required under state and federal laws. Feel free to also include a clinical rationale for the requested medication in the space below.	Clinical documentation attached? YES ☐ NO ☐ *(Requests may be considered incomplete if medical records or other documentation is not attached)*

Clinical Rationale:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature	Date