## **ANTI-INFLUENZA AGENTS**

## QUANTITY LIMIT REQUEST

## PRESCRIBER FAX FORM

ONLY the provider may complete this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit <a href="https://www.bcbstx.com/provider/medicaid/rx\_prior\_auth.html">https://www.bcbstx.com/provider/medicaid/rx\_prior\_auth.html</a> PATIENT AND INSURANCE INFORMATION Today's Date:

Patient Name (First):       Last:       Mt       DOB (mm/ddyyyy):         Patient Address:       City, State, Zip       Patient Telephone:         BCBSTX ID Number:       Group Number:       Contact Name:         Prescriber Name:       Prescriber NPI#:       Specialty:       Contact Name:         Clinic Name:       Prescriber NPI#:       Specialty:       Contact Name:         PLASS ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST       Platent's Diagnosis - ICD code plus description:         Medication Requested:       Strength:       Deanity per Month:         Dasing Schedule:       Strength:       Quantity per Month:         1       Is the patient currently treated with the requested dose stated?       If yes, when was treatment with the requested ducation of therapy for prophidas after exposure to an influenza-infected person?       Image: No         3. Does the patient require additional courses or increased duration of therapy for prophidas after exposure to an influenza-infected person?       Image: No         4. Is the requested medications supply shortage?       Date(s):       Date(s):         Date(s):       Date(s):       Date(s):       Date(s):         Date(s):       Date(s):       Date(s):       Date(s):         Date(s):       Date(s):       Date(s):       Date(s):         Date(s):	PATIENT AND INSURANCE INFOR					ouay	S Dale	
BCBSTX ID Number: Group Number:   PRESCRIBER/CLINIC INFORMATION   Prescriber Name: Prescriber NPIH:   Specially: Contact Name:   Clinic Name: Clinic Address:   Clinic Name: Clinic Address:   PLASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST   Patient's Diagnosis - ICD code plus description:   Medication Requested: Strength:   Dosing Schedule: Quantity per Month:   1. Is the patient currently treated with the requested dose of the requested medication?   Quantity per Month:   1. Is the patient currently treated with the requested dose stated?   Quoes the patient require additional courses of increased duration of therapy for prophylaxis after exposure to an influenza-infection person?   Quantity:   Quantity:   Quantity:   Dete(s):   Date(s):   Quantity:	Patient Name (First):	Last:				M: DOB (mm/dd/yyyy):		
PRESCRIBER/CLINIC INFORMATION           Prescriber Name:         Prescriber NPI#:         Specially:         Contact Name:           Clinic Name:         Clinic Address:         Secure Fax #:           Please ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST         Patient's Diagnosis - ICD code plus description:           Medication Requested:         Strength:         Desing Schedule:         Quantity per Month:           1. Is the patient require additional courses of therapy due to additional episodes of acute influenza infection?         Yes   No           3. Does the patient require additional courses of therapy due to additional episodes of acute influenza infection?         Yes   No           4. Is the requested medication in supply shortage?         Yes   No           5. Please list all reasons for selecting the requested medication, quantity and dosing schedule (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried.)           6. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient) will use in combination with the requested medication for treatment of this diagnosis. (Please specify if the patient):           9.         Date(s):         Date(s):           9.         Date(s):         Date(s):           9.         Date(s):         Date(s):           9.         Date(s):         Date(s):	Patient Address:	Address: City, State, Zip			Patient Telephone:			
Prescriber NPI#:       Specialty:       Contact Name:         Clinic Name:       Clinic Address:         City, State, Zip:       Phone #:       Secure Fax #:         PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST         Patient's Diagnosis - ICD code plus description:       Medication Requested:         Medication Requested:       Strength:         Dosing Schedule:       Quantity per Month:         1       Is the patient currently treated with the requested dose of the requested medication?       Yes   No         # yes, when was treatment with the requested dose started?       Quantity per Month:       Yes   No         2. Does the patient require additional courses or increased duration of therapy for prophylaxis after exposure to an influenza-infected person?       Yes   No         4. Is the requested medication in supply shortage?       Yes   No         5. Please list all medications to alternatives, lower dose tried.)       Quantity:       Quality:         Quantity:       Date(s):       Date(s):       Date(s):         Quantity:       Quantity:       Quantity:       Quantity:         Quantity:       Quantity:       Quantity:       Quantity:         Quantity:       Quantity:       Quantity:       Quantity:         Quantity:       Quantity:       Quantity: <t< td=""><td colspan="7">BCBSTX ID Number: Group Number:</td></t<>	BCBSTX ID Number: Group Number:							
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<ul> <li>3. Does the patient require additional courses or increased duration of therapy for prophylaxis after exposure to an influenza-infected person?</li> <li>Wes □ No</li> <li>4. Is the requested medication in supply shortage?</li> <li>No</li> <li>5. Please list all reasons for selecting the requested medication, quantity and dosing schedule (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried.)</li> <li>6. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products.)</li> <li>□ Date(s): Quantity: provider to the substitute for the independent medical judgment of a treating physician. Only a treating physician cone determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, continues, and exclusions. The submitting provider tert the notomation provided is true, accurate, and complete and the requested services are me</li></ul>								
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