BINGE EATING DISORDER (BED)
PRIOR AUTHORIZATION
PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax 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 prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/rx_prior_auth.html

PATIENT AND INSURANCE INFORMATION **Today's Date:**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	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: _____

Please provide the date of diagnosis: _____

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
   If yes, please provide start date and current dosing schedule: _____
2. Has the patient had at least 60 days of therapy with an agent for the treatment of Binge Eating Disorder (BED) in the last 60 days? ☐ Yes ☐ No
   If yes, please provide list of therapy agents: _____
3. Does the patient have any of the following in the last 365 days? (check all that apply) ☐ Yes ☐ No
   ☐ history of substance abuse ☐ severe cardiac disease
   ☐ severe renal impairment ☐ end stage renal disease (ESRD)
4. Please list all reasons for selecting the requested **medication, quantity and dosing schedule** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried). _____
5. 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.)
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
6. Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. **(Please include strength and quantity per month)**
   _____ Quantity: _____ _____ Quantity: _____
   _____ Quantity: _____ _____ Quantity: _____

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility Authorization does not guarantee payment.

Please fax or mail this form to:
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TOLL FREE

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