CHLOROQUINE/HYDROXYCHLOROQUINE PRIOR AUTHORIZATION REQUEST

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 Name (First):	PATIENT AND INSURAN	T	Today's Date:						
BCBSTX ID Number: PRESCRIBER/CLINIC INFORMATION Prescriber Name: Clinic Address: PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST Patient's Diagnosis-ICD code plus description: Medication Requested: Strength: Dosing Schedule: Countity per Month: For all requests: 1. Is the patient currently treated with the requested medication started? 2. Is the requested agent being used for any of the following? (Please check all that apply) Manual (prophysias or treatment) Manual (prophysias) Manual (prophys	Patient Name (First):					M:	DOB (mm/dd/yy):		
PRESCRIBER/CLINIC INFORMATION Prescriber Name: Clinic Address:	Patient Address:	Patient Address: City, State,		:		Patient Telephone:			
Prescriber Name: Prescriber NPI#: Specialty: Contact Name:	BCBSTX ID Number:				Group Number:				
Clinic Name: City, State, Zip: Phone #: Secure Fax #: Please TATACH 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: For all requests: 1 is the patient currently treated with the requested medication?	PRESCRIBER/CLINIC INI	FORMATION							
City, State, Zip: Phone #: Secure Fax #: PEABER 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: For all requests: 1. Is the patient currently treated with the requested medication?	Prescriber Name: Prescriber NPI#:				Specialty:		Contact Name:		
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Medication Requested: Dosing Schedule: Quantity per Month:				SHOU	LD BE CONSIDERED	WITH	THIS REQUEST		
Dosing Schedule:	-	code plus description	:						
See a patient currently treated with the requested medication? Yes No If yes, when was treatment with the requested medication started?	Medication Requested: Strength:								
1. Is the patient currently treated with the requested medication?	Dosing Schedule: Quantity per Month:								
If yes, when was treatment with the requested medication started?	For all requests:								
2. Is the requested agent being used for any of the following? (Please check all that apply)	1. Is the patient current	ly treated with the re	quested medicat	ion?			Yes	☐ No	
COVID-19	If yes, when was treatment with the requested medication started?								
COVID-19									
Malaria (prophylaxis or treatment) Rheumatoid arthritis		-	-					_	
3. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): 4. Please list all other medications the patient is currently taking for treatment of this diagnosis: 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):									
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Date(s):		nd-name products, ge	eneric products,	or ove					
Date(s): Date(s): Date(s):									
For COVID-19 treatment: 6. Does the patient require an additional course of therapy?									
6. Does the patient require an additional course of therapy?		Da	te(s):	_			Date(s):		
7. Does the patient require treatment beyond 10 days of therapy?	For COVID-19 treatmen	t:							
8. Is the patient's dosing over the plan's set limit? (If yes, clinical references must be submitted)	6. Does the patient require an additional course of therapy?						Yes	☐ No	
Prescriber or Authorized Signature: 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: Prime Therapeutics LLC, Clinical Review Department 2900 Ames Crossing Road Information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 866.202.3474 and return the original message to Prime Therapeutics via U.S. Mail. Thank you for	, , , , , , , , , , , , , , , , , , , ,						Yes	☐ No	
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: Prime Therapeutics LLC, Clinical Review Department 2900 Ames Crossing Road	8. Is the patient's dosing over the plan's set limit? (If yes, clinical references must be submitted)								
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