COLCHICINE AGENTS 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): Last: M: DDB (mm/dd/yy): Patient Address: City, State, Zp: Patient Telephone: BCBSTX ID Number: Group Number: Contact Name: Prescriber Name: Prescriber NPI#: Specialty: Contact Name: Citic Name: Citic Address: Citic Address: City, State, Zp: Phone #. Secure Fax #. Petaset ATACH ANY ADDITIONAL INFORMATION THAT SHOLLD BE CONSIDERED WITH THIS REQUEST Patient's Diagnosis-ICD code plus description: Medication Requested: Strength: Does ing Schedule: Quantity per Month: 1. Is the patient nave a diagnosis of renal or hepatic impairment in the last 365 days? Q via City or Cit	PATIENT AND INSURANCE INFORMATION Today's Date:							
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Date(s):								
 5. Please list all reasons for selecting the requested medication over alternatives (e.g., contraindications, allergies or history of adverse drug reactions). 6. Please list all other medications the patient is currently taking for treatment of this diagnosis. 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: Prime Therapeutics LLC, Clinical Review Department 2900 Ames Crossing Road Eagan, Minnesota 55121 TOLL FREE Fax: 877.243.6930 Phone: 855.457.0407 								
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