

# 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](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. 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). \_\_\_\_\_  
 \_\_\_\_\_

3. 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): \_\_\_\_\_

4. 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: \_\_\_\_\_

**For Narcotic Analgesic or Opioid Dependence (e.g., Suboxone) Agents**

5. Is the requested medication for management of pain due to active malignancy or the patient is enrolled in a hospice program or meets hospice criteria for life expectancy of six months or less?.....  Yes  No  
**If no**, please submit documentation of a formal evaluation including diagnosis and a complete medical history including previous pharmacological and non-pharmacological therapy.

**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**

**CONFIDENTIALITY NOTICE:** This communication is intended only for the use of the individual entity to which it is addressed and may contain 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 your cooperation.