



Outpatient Prescription Drug Prior Authorization of Benefits Form

FAX TO THE PRIOR AUTHORIZATION OF BENEFITS CENTER AT (888) 831-2243

Patient Name: _____ Prescribing Physician: _____
 Patient ID #: _____ Physician DEA #: _____
 Patient DOB: _____ Physician Telephone: _____
 Date of Rx: _____ Physician FAX: _____
 X _____ Date Signed: _____

Signature of physician or provider

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 Blue Cross plan for detailed information regarding benefits, conditions, limitations and exclusions.

Please list medication requested: _____
(One medication per request form)

Medical justification:

Physician specialty: _____

Diagnosis: _____

Treatment failure: _____

Adverse event: _____

Other (please specify): _____

If request is for anorexiant or weight loss drugs please indicate BMI: _____

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