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 anorexiants or weight loss drugs please indicate BMI: _____

PLEASE COPY BLANK FORM FOR FUTURE USE