BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

GENERAL PRESCRIPTION DRUG COVERAGE AUTHORIZATION REQUEST FORM

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

GENERAL INFORMATION

Request Type (please check one)

- ☐ Prior Authorization
- ☐ Step Therapy Exception
- ☐ Request for Quantity Limit Exception
- ☐ Appeal
- ☐ Mandatory Generic Exception
- ☐ Request for Non-Formulary Exception

Patient Name

Patient's Home Address

City | State | Zip

Date of Birth (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Contract Number (include prefix)

PRESCRIBER INFORMATION

Prescriber Name

Practice Address

City | State | Zip

Office Phone | Office Fax

Practice Type
- ☐ PCP
- ☐ Specialty: _____

National Provider Identifier (NPI)

REQUEST TYPE

(Please check one) ☐ **Initial Authorization** ☐ **Authorization Renewal** (Please attach any additional medical information.)

TREATMENT INFORMATION

Drug/Strength/Frequency/Quantity Requested:

Duration of Disease (Years):

Place of Services:

Route of Administration:

Healthcare Professional to Administer: ☐ Yes ☐ No

ICD-10 Codes:

Medical rationale for use (include chart notes if possible):

List medications this patient has tried for this condition (include current medications and titration history if applicable)

Drug	Strength/Frequency	Dates of Therapy	Outcome of Therapy
1.			
2.			
3.			
4.			
5.			

Does this patient have any co-morbid conditions that will affect therapy: ☐ Yes ☐ No
If so, please list: _____

Note: Medications received through manufacturer coupons or samples are not accepted as justification of prior therapy.

Prescriber Signature

(Required for processing request)

I certify this information is complete and correct to the best of my knowledge.

Prescriber Signature | Date

Please attach any additional medical justification.

SUBMISSION INSTRUCTIONS

FAX You may fax the signed and completed form to Pharmacy Review at:
1-866-606-6021

MAIL *You may mail the signed and completed form to:*
Pharmacy Review
Post Office Box 3210 • Auburn, AL 36831