Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

Anthem BlueCross BlueShield

Prior Authorization Form for Medical Injectables

If the following information is not complete, correct and/or legible, the prior authorization (PA) process may be delayed. Use one form per member.

Member information

Last name **First name**

Member ID number **Date of birth** - -

****Required****

☐ **Male** ☐ **Female** **Height** _____ **Weight**_____

Member's place of residence: ☐ Home ☐ Nursing facility

Administration location: ☐ Home ☐ Office ☐ Outpatient facility

Prescriber information

Last name **First name**

NPI **Tax ID**

Phone **Fax**

Prescriber information/demographics

Address where service was rendered:	**City:**	**State:**

ZIP code:	**Office contact name:**	**Contact direct phone number:**

Is the address above also the billing address? ☐ **Yes** ☐ **No** (If no, please complete the section below.)

Billing facility information

Facility name

NPI **DEA #**

Contact person for billing facility:

Last name **First name**

Phone **Fax**

Medication information

Drug name and strength requested:	**SIG (dose, frequency and duration):**	**HCPCS billing code:**

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Medication information (cont.)

Has the member tried other medications to treat this condition?

☐ Yes. Please provide this information in the area to the right. You may be asked to provide supporting documentation such as copies of medical records, office notes or a completed *FDA MedWatch* form.

☐ No. Explain why not:

_____

_____

_____

_____

_____

_____

Drug(s) name and strength:

Date range of use:

SIG (dose and frequency):

Did member experience any of the below?

☐ Adverse reaction ☐ Inadequate response

☐ Other

Briefly describe details of the adverse reaction, inadequate response or other in the space provided below.

_____

_____

Describe the reason nonpreferred medication(s) or prescribing outside of FDA labeling is medically necessary: _____

_____

List all current medications, including dose and frequency: _____

_____

Other pertinent information: _____

Diagnostic studies and/or laboratory tests performed

(List all tests done within the past 30 days that are related to the diagnosis or the medication requested.)

Labs			Diagnostic tests		
Test	**Date**	**Result**	**Procedure**	**Date**	**Result**

Diagnosis and/or indication:

ICD code (required):

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission or concealment of material may be subject to civil or criminal liability.

Prescriber signature (required): _____ **Date:** _____

Fax this form to 1-888-209-7838.

For telephone PA requests or questions, please call 1-844-533-1995 for Healthy Indiana Plan members, 1-844-284-1798 for Hoosier Care Connect members or 1-866-408-6132 for Hoosier Healthwise members.

Please allow Anthem Blue Cross and Blue Shield at least 24 hours to review this request.