Anthem BlueCross BlueShield Medicaid

Prior Authorization Form — Medical Injectables

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

Member information

Last name: ______ **First name:** ______

Member ID: ______ **Date of birth:** __ __ – __ __ – __ __ __ __

Member information
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 rendered:	City:	State:
ZIP code:	Office contact name:	Contact's direct phone number:
Is the above address also the billing address? ☐ Yes ☐ No (If no, please complete 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:
Diagnosis and/or indication:		ICD code (required):

Continued on page 2 (required)

Fax this form to 1-844-487-9289.

For telephone PA requests or questions, please call 1-855-661-2028.

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

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ACCREDITED NCQA HEALTH PLAN

Has member tried other medications to treat this condition?	Drug(s) name and strength:	
☐ Yes. 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 complete FDA MedWatch form. ☐ No. Explain why not. ____ ____ ____ ____	**Date range of use:**	**SIG (dose and frequency):**
	Did member experience any of the below? ☐ Adverse reaction ☐ Inadequate response ☐ Other Briefly describe details of adverse reaction, inadequate response or other in the space provided below.	

Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:
____
____

List all current medications, including dose and frequency:
____
____

Other pertinent information:
____
____

Diagnostic studies and/or laboratory tests performed (List all tests performed within the past 30 days that are related to diagnosis for medication requested.)

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

Prescriber signature (required):____

Date: ____________________

By signing, the prescriber confirms the above information is accurate and verifiable by patient records and understands that any falsification, omission or concealment of material may be subject to civil or criminal liability.

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