Anthem. BlueCross BlueShield Medicaid

Global Nonpreferred Prior Authorization Form

Please complete, sign and date this form. Fax it to Anthem Blue Cross and Blue Shield Medicaid (Anthem) at **1-844-879-2961**. Please contact Anthem at **1-855-661-2028** with questions regarding the prior authorization process.

Drug name (please specify): ____

Patient information

Patient name: ______________________ Patient ID #:______________________

Patient group number: ______________________ Patient DOB: ______________________

Prescriber information

Physician name: ______________________ NPI #: ______________________

Physician phone #: ______________________ Physician fax #: ______________________

Physician address: ____

City, State ZIP code: ____

Diagnosis

Diagnosis: ______________________ ICD code: ______________________

Please circle the appropriate answer for each question.

1. Is this an office-administered injectable drug? Yes No
2. Did the patient have an intolerance for or allergic reaction to a preferred drug? Yes No

   If yes, please submit documentation, including medication(s) tried, date(s) of trial(s) and reaction to medication(s). (If the answer to this question is yes, no further questions are required.)
3. Did the patient have an inadequate response to a trial of a preferred drug? Yes No

   If yes, please submit documentation, including medication(s) tried, date(s) of trial(s) and reason for treatment failure(s). (If the answer to this question is yes, no further questions are required.)
4. Do the preferred drugs have inappropriate formulations or different indications than the requested drug? Yes No

   If yes, please submit documentation specifying the formulation or indication.
5. Is the drug being prescribed within the manufacturer's published dosing guidelines, or does it fall within dosing guidelines found in the compendia of current literature (for example, package insert, AHFS, Micromedex®, current accepted guidelines, etc.)? Yes No
6. Is the drug being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program? Yes No

Comments: ____

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I affirm that the information given on this form is true and accurate as of this date.

Prescriber or authorized signature: ______________________ **Date:** ______________

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