Empire BlueCross BlueShield

An Anthem Company

Prior Authorization Form — Medical Injectables

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

PA criteria can be found on our provider website, **www.empireblue.com/nymedicaiddoc**.

Member information		
Last name:	First name:	
ID number:	DOB:	
☐ Male ☐ Female	Height:	Weight:
Place of residence: ☐ Home, ☐ Nursing facility		
Administration location: ☐ Home ☐ Office ☐ Outpatient facility		
Prescriber information		
Last name:	First name:	
NPI #:	TIN:	
Phone:	Fax:	
Address where service rendered:		
City, State Zip:		
Is the above address also the billing address? ☐Yes ☐ No (If no, complete section below.)		
Office contact name:		
Contact direct phone number:		
Billing facility information		
Facility name:		
NPI #:	DEA #:	
Contact person name:		
Phone:	Fax:	
Medication information		
Drug name and strength requested:		
SIG (dose, frequency and duration):		
HCPCS billing code:	ICD code:	
Diagnosis and/or indication:		

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Medication information (cont.)		
Has the member tried other medications to treat this condition?		
☐ Yes	If yes, please provide specifics: Note, you may be asked to provide supporting documentation such as copies of medical records, office notes and complete *FDA MedWatch Form*.	
	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 adverse reaction, inadequate response or other: _____ _____ _____
☐ No	If no, please explain why not: _____ _____ _____	
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 done within the past 30 days that are related to diagnosis for medication requested.		
Labs:		
Test:	**Date:**	**Result:**
Diagnostic tests:		
Procedure:	**Date:**	**Result:**
By signature, 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.		
Prescriber signature:		
Date:		

Fax this form to **1-844-493-9206.**
For PA requests by phone or for questions, call Provider Services at **1-800-450-8753**.

Please allow Empire BlueCross BlueShield HealthPlus at least 24 hours to review this request.