Empire BlueCross BlueShield
An Anthem Company

Medicaid

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 by searching the **clinical criteria website**.

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 number:	Tax ID:	
Address:	City:	
State/ZIP:	Phone:	Fax:
Office contact name:	Contact direct phone:	
Is the above prescriber also the administering provider? ☐Yes ☐ No (If no, complete section below.)		
Administering provider information		
Last name:	First name:	
NPI number:	Tax ID:	
Address:	City:	
State/ZIP:	Phone:	Fax:
Office contact name:	Contact direct phone:	
Is the above prescriber also the administering provider? ☐Yes ☐ No (If no, complete section below.)		
Billing facility information		
Facility name:	Contact person name:	
NPI number.:	Tax ID:	DEA/License number:
Full address:		
Phone:	Fax:	
Medication information		
Drug name and strength requested:		

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<table>
<tr><td colspan="3">SIG (dose, frequency, and duration):</td></tr>
<tr><td colspan="2">HCPCS billing code:</td><td>ICD code:</td></tr>
<tr><td colspan="3">Diagnosis and/or indication:</td></tr>
<tr><td colspan="3">Medication information (cont.)</td></tr>
<tr><td colspan="3">Has the member tried other medications to treat this condition?</td></tr>
<tr><td rowspan="5">☐ Yes</td><td colspan="2">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.</td></tr>
<tr><td colspan="2">Drug(s) name and strength:</td></tr>
<tr><td colspan="2">Date range of use:</td></tr>
<tr><td colspan="2">SIG (dose and frequency):</td></tr>
<tr><td>Did member experience any of the below?
☐ Adverse reaction
☐ Inadequate response
☐ Other</td><td>Briefly describe details of adverse reaction, inadequate response, or other:</td></tr>
<tr><td>☐ No</td><td colspan="2">If no, please explain why not:</td></tr>
<tr><td colspan="3">Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:</td></tr>
</table>

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 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.
Prescriber signature:
Date:

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

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