

Outpatient Retail Pharmacy Prior Authorization

FAX TO: CLINICAL PHARMACY PROGRAM (800) 583-6289 PHONE: (800) 366-7778

We will respond to your request within two business days of our receipt. We need to confirm your request (required by NCQA), so please be sure to include your fax number. We cannot process requests unless they contain all of the information requested below:

Patient Information (Required)

Name _____ BCBSMA ID Number _____

Is the Patient a BCBSMA Employee? Yes No

Date of Birth _____

Patient's Diagnosis _____

ICD-9-CM Code _____

Physician Information (Required)

Name _____ Medical Specialty _____

BCBSMA Provider Number _____

Telephone Number _____ Fax Number _____

Contact Name (If Different from Physician) _____

Please Select One of the Three Following Sections to Complete, Depending on the Nature of Your Request for the Above-Named Patient.

Formulary Exception Request

Name of Non-Covered Drug You Want to Prescribe _____

Reason for Individual Consideration Request (Please Check One):

Treatment Failure with all Covered Drugs in Class

Documented Adverse Reaction to all Covered Drugs

Other Clinical Reason (Please Specify) _____

Quality Care Dosing Override Request

Drug name, strength and quantity requested _____

Clinical reason for override (please specify) _____

Outpatient Retail Pharmacy Prior Authorization Request

Drug Name _____

Start/End Date (Must Be One Year or Less) _____

For Epogen[®] Only:

Serum Creatinine _____ Creatinine Clearance _____

Is Patient Certified ESRD with Medicare? _____



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