



**Independence
Blue Cross**

General Prior Authorization Form

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Gender Edit
 Quantity Edit
 Age Edit
 Prior Authorization

Drug Requested _____
(one drug per form only)

Quantity _____
(qty. edit only)

Date: _____

Patient ID#: _____ DOB: _____

Patient Name: _____

Provider NPI: _____

Prescribing Physician: _____

Office Contact: _____

Office Fax #: _____

Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

*****MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE*****

1. PROVIDER SPECIALTY (specify all) _____

2. DIAGNOSIS FOR DRUG REQUESTED (specify all) _____

3. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

Drug Name (dose and frequency)	Duration of therapy (include dates)	Currently prescribed	Compliant
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL