BlueCross BlueShield of Western New York

Prior Authorization (PA) form — Medical Injectables

This BlueCross BlueShield of Western New York (BlueCross BlueShield) *PA form* and PA criteria may be found by accessing **www.bcbswny.com/stateplans**.

If the following information is not complete, correct or legible, the PA process can be delayed. Use one form per member.

Member information

Last name **First name**

BlueCross BlueShield ID number **Date of birth** ___

****Required****

☐ **Male** ☐ **Female** **Height____** **Weight____** **Member's place of residence:** ☐ **Home** ☐ **Nursing facility**

Administration location: ☐ **Home** ☐ **Office** ☐ **Outpatient facility**

Prescriber information

Last name **First name**

NPI number **Tax ID number**

Phone **Fax**

Prescriber demographics		
Address where service rendered:	**City:**	**State:**
ZIP code:	**Office contact name:**	**Contact direct phone number:**
Is the above address also the billing address?	☐ **Yes** ☐ **No (If no, please complete below.)**	

Billing facility information

Facility name

NPI number **DEA number**

Contact person for billing facility

Last name **First name**

Phone **Fax**

Medication information		
Drug name and strength requested:	**Sig codes: (dose, frequency and duration)**	**HCPCS billing code:**
Diagnosis and/or indication:		**ICD code: (required)**

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Has the member tried other medications to treat this condition? ☐ Yes: Provide this information in the area to the right. You may be asked to provide supporting documentation such as copies of medical records, office notes, complete FDA MedWatch form. ☐ No: Explain why not: _____ _____ _____ _____ _____	**Drug(s) name and strength:** **Date range of use:** / **Sig codes: (dose and frequency)** **Did the member experience any of the below?** ☐ Adverse reaction ☐ Inadequate response ☐ Other Briefly describe details of adverse reaction, inadequate response or other in the space below.

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:				**Diagnostic tests:**		
Test	**Date**	**Result**		**Procedure**	**Date**	**Result**

Prescriber signature (Required): _____ Date: _____

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.

Fax this form to **1-800-359-5781**.

For telephone PA requests or questions, call **1-866-231-0847**.

Allow BlueCross BlueShield at least 24 hours to review this request.