



**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

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)

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please add any other supporting medical information that may be useful in the decision-making process:

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

Internal use only	Coverage effective date / /
Document # _____	Processor Initials _____ Date _____
M F Rx coverage Y N	STANDARD - SELECT LOB _____
Previous Auth Y N	Approved Reviewer Initials _____ Date _____