Prior Authorization Form

EFFIENT®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)* ☐ **Effient®** ☐ **Other (specify)** ____________________

Date: ________________________ Patient ID#: ______________ DOB:__________

Patient Name: ____________________________ Provider NPI: ____________________________

Prescribing Physician: ______________________ Office Contact: ___________________________

Office Fax #: _____________________________ Office Phone: ____________________________

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

☐ Acute Coronary Syndrome (ACS)
☐ Other (specify)_________________________

2. 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

3. PATIENT HISTORY:

a. Is the patient managed with Percutaneous Coronary Intervention (PCI)? ☐ Yes ☐ No

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

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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____________

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Provider Communication

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield. Independent licensees of the Blue Cross and Blue Shield Association.