

Prior Authorization (PA) form — Medical Injectables This BlueCross BlueShield of Western New York (BlueCross BlueShield) <i>PA form</i> and PA criteri	a 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. Member information								
Last name First name								
BlueCross BlueShield								
D number Date of birth								
Required <hr/> Male Female Height Weight Member's place of residence: Home facility								
Administration location: Home Office Outpatient facility								
Prescriber information								
Last name First name								
NPI number								
Phone Fax								
Prescriber demographics								
Address where service rendered: City:	State:							
ZIP code: Office contact name: Contact direct ph	one number:							
Is the above address also the billing address? I Ves 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)							

www.bcbswny.com/stateplans

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Has the men	nher tri	ed other medications	Drug(s) name	and strend	₁th•				
to treat this c			Drug(s) name and strength:						
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.		Date range of	f 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:									
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:				Diagnost	ic tests:				
Test	Date	Result			Procedure	Date	Result		
Prescriber si	ionatu	re (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.

Protected health information (PHI): These documents contain PHI. Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call 1-866-231-0847.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.