Independence Blue Cross

General Prior Authorization Form

ONLY COMPLETED REQUESTS WILL BE REVIEWED

☐ Gender Edit ☐ Quantity Edit ☐ Age Edit ☐ Prior Authorization

Drug Requested _____ Quantity _____
(one drug per form only) (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
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ 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: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL