BlueCross BlueShield
of Western New York

Preauthorization/Non-Formulary Medication Request Form

Fax (716) 887-8981 or toll-free fax 1-866-221-5784

Toll-free telephone 1-800-716-3230

BlueCross BlueShield use only

Date: _____

Patient name: _____

ID #: _____ DOB: / /

Diagnosis: _____

Medication requested: _____

Dosage and regimen prescribed: _____ Anticipated duration*: _____

*Maximum duration for approvals is one year, and may be less for acute care or at plan discretion.

Justification for request
(Where applicable, please list other medication, allergies, or therapeutic measures attempted and results; additional supporting documentation, such as lab reports and test results, should also be attached):

Medications tried:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Prescriber name (please print): _____

Prescriber specialty: _____

Prescriber signature: _____

DEA #: _____ NPI: _____

Telephone #: ( ) _____ Fax: ( ) _____

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☐ **Pended (Information needed to complete request. our decision is pending your response):**

Date pended request will close: _____/_____/_____

Date: _____/_____/_____ Signature: _____

Determination: ☐ Denied ☐ Approved Time period: _____

Reason:

Date: _____/_____/_____ Signature: _____

Approvals are valid only if person has active prescription drug coverage through BlueCross BlueShield of Western New York. This preauthorization is subject to all drug therapy guidelines in effect at the time of the approval and other terms, limitations an provisions in the member's contract/rider. We reserve the right to update and/or modify our drug therapy guidelines for prospective services.