



Preauthorization/Non-Formulary Medication Request Form

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

Toll-free telephone 1-800-939-3751

BlueCross BlueShield use only

The information contained in this facsimile may be considered protected health information. The recipient of this information is obligated to protect the confidentiality of this information and maintain it in a safe and secure manner. Re-disclosure of the information without the patient's, or their authorized representatives' permission, or as otherwise permitted by law, is strictly prohibited. Unauthorized use or disclosure of this information or failure to maintain the confidentiality could subject you to civil and/or criminal penalties. This information is confidential and is intended only for the exclusive use of the individual or entity name above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this message in error, please notify the sender by telephone immediately to arrange for its return.

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:

Blank lines for justification and 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: / /

Blank lines for pended request details.

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 and provisions in the member's contract/rider. We reserve the right to update and/or modify our drug therapy guidelines for prospective services.