Prior Authorization Request for
MEDICATIONS, DME, AND MEDICAL DEVICES

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

(* = Required Field)

1 — SUBMISSION INFORMATION

Name	Phone	Fax	Date
			/ /

2 — REASON FOR REQUEST

Check one* ☐ Initial Request ☐ Continuation/Renewal Request

Reasons for request:* (Check all that apply)

☐ Prior Authorization	☐ Specialty Drug	☐ Other (please specify below)
☐ Step Therapy, Formula Exception	☐ Medical Device	
☐ Quantity Exception	☐ Durable Medical Equipment (DME)	

3 — EXPEDITED/URGENT REVIEW

☐ **Expedited/Urgent Review Requested –** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee:

/s/

4 — PATIENT INFORMATION

Name*	Phone*	DOB*	Gender*
		/ /	☐ Male ☐ Female

Address*	City*	State*	ZIP Code*

Subscriber Name (if different from above)	Member ID #*	Group Name or Number	BIN #	PCN	Rx ID #

5 — PRESCRIBER/ORDERING PROVIDER INFORMATION*

Name	NPI #	Specialty

Address	City	State	ZIP Code

Phone	Fax	Office Contact Name	Contact Phone

6 — PRESCRIPTION DRUG INFORMATION (if this is a compound drug, identify all ingredients in the next section)

Requested Drug Name

Strength	Route of Administration	Quantity	Days' Supply	Expected Therapy Duration

To the best of your knowledge this medication is:		Approximate date therapy was initiated (if this is for continuation)
☐ New therapy	☐ Continuation of therapy	

For provider-administered drugs only:

CPT/HCPCS Code	NDC #	Dose Per Administration

7 — COMPOUND DRUG INFORMATION

Compound Drug Name					
Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

8 — PRESCRIPTION DME OR MEDICAL DEVICE INFORMATION

Requested DME or Medical Device Name	Expected Duration of Use	HCPCS Code (If applicable)

9 — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request*	ICD Version*	ICD Code*

Drugs patient has taken for this diagnosis (provide the following information to the best of your knowledge)

Drug Name	Strength	Frequency	Dates Started/Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies	Height (if applicable)	Weight (if applicable)

Relevant laboratory values and dates (attach or list below)

Date	Test	Value
/ /		
/ /		
/ /		
/ /		

10 — JUSTIFICATION (provide or attach any additional justification here, such as notes, treatment plans, lab/test results, etc.)

SAVE and fax this form to BCBSAZ at 1-844-263-2272.

If you have questions, call us at 602-864-4320 or 1-800-232-2345.

1336073-23