



Drug Prior Authorization Request Form

(Incomplete Form May Delay Processing)

Prescriber Information		Patient Information	
Physician Name:		Patient Name:	
Office Contact Person:		Patient ID # :	
Office Phone # :	Office Fax # :	Home Phone # :	
Address:		Sex (circle): M F	DOB:
City:	State:	Zip:	
Medication Requested			
Medication:	Strength and Route of Administration:	Frequency:	
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Qty: _____ per _____ days	
Rationale for Prior Authorization FORM CANNOT BE PROCESSED WITHOUT EXPLANATION			
Diagnosis: _____ _____			
What other drug(s), if any, has the patient taken in the past for this condition, and what was the patient's response? _____ _____			
Part D vs. Part B coverage: Certain drugs require prior authorization because Part D coverage of these drugs is available only if coverage is not available under Part B. (See http://www.cignagovernmentservices.com/partb/coverage/index.html#policies for Part B coverage clarification). If pertinent, specify below why this drug(s) is covered under the Part D benefit rather than Part B: _____ _____			
Additional information we should consider (attach any supporting documents): _____ _____ _____			
I certify that, to the best of my knowledge, the above information is accurate.			
Physician Signature: _____		Date: _____	

Please Return Completed Form to: Fax number: 1-888-446-8535
 Address: BCBSNC, Attention: Exceptions-Healthcare Services
 P.O. Box 17509, Winston-Salem, NC 27116-7509
 Provider telephone: 1-888-296-9790

4/2010