

## 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<br>Date Therapy Initiated:   | Expected Length of Therapy:           | Qty: _____ per _____ days |      |
| Rationale for Prior Authorization<br>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? _____  |                                       |                           |      |
| _____   |                                       |                           |      |
| <b>Part D vs. Part B coverage:</b> Certain drugs require prior authorization because Part D coverage of these drugs is available only if coverage is not available under Part B. (See <a href="http://www.cignagovernmentservices.com/partb/coverage/index.html#policies">http://www.cignagovernmentservices.com/partb/coverage/index.html#policies</a> for Part B coverage clarification).<br>If pertinent, specify below why this drug(s) is covered under the Part D benefit rather than Part B: _____ |                                       |                           |      |
| _____   |                                       |                           |      |
| <b>Additional information we should consider</b> (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

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