



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? _____ | | | |
| <p>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: _____</p> | | | |
| 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: 1-888-446-8440

Address: BCBSNC. Attention: Exceptions-Health Services
P.O. Box 17168

Winston-Salem, NC 27116-7168

Provider Line Telephone: 1-888-298-7552

9/2009