Anthem Blue Cross

Global Non-formulary Prior Authorization Form

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Anthem Blue Cross and Blue Shield Medicaid at **1-855-875-3627**. Please contact Anthem Blue Cross and Blue Shield Medicaid at **1-855-661-2028** with questions regarding the prior authorization process.

Drug Name

Please specify:

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Patient Information

Patient Name: ___________________________________

Patient ID: ___________________________________

Patient Group No.: ___________________________________

Patient DOB: ___________________________________

Prescribing Physician

Physician Name: ___________________________________

NPI: ___________________________________

Physician Phone: ___________________________________

Physician Fax: ___________________________________

Physician Address: ___________________________________

City, State ZIP Code: ___________________________________

Diagnosis: ______________________________ **ICD Code:** ______________________________

Please circle the appropriate answer for each question.

	Question		
1.	Is this an office-administered injectable drug?	☐ **YES**	☐ **NO**
2.	Is the intent to provide and bill for this medication at the physician's office? (If the answer to this is yes, then please call Provider Services at **1-855-661-2028** or fax Provider Services at **1-855-875-3627** for review.)	☐ **YES**	☐ **NO**
3.	Is the requested drug being used for an FDA-approved indication?	☐ **YES**	☐ **NO**
4.	Is the requested drug being used for an indication that is supported by information from the appropriate compendia of current literature (e.g., AHFS, Micromedex, current accepted guidelines, etc.)?	☐ **YES**	☐ **NO**
5.	Has the patient demonstrated a failure of or intolerance to a majority (not more than three) of the preferred formulary/PDL alternatives for the given diagnosis?	☐ **YES**	☐ **NO**

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6.	Is the drug being prescribed within the manufacturer’s published dosing guidelines or falls within dosing guidelines found in the compendia of current literature (e.g., package insert, AHFS, Micromedex, current accepted guidelines, etc.)?	☐ **YES**	☐ **NO**
7.	Is the drug being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan’s program?	☐ **YES**	☐ **NO**

Comments: ____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber or Authorized Signature and Date:

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Important Note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool or sent in any medium, including mail, email, fax or other electronic transmission.