



**Arkansas
BlueCross BlueShield**
An Independent Licensee of the Blue Cross and Blue Shield Association



Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association



**BlueAdvantage
Administrators of Arkansas**
An Independent Licensee of the Blue Cross and Blue Shield Association

Physician's Prior Authorization Request

Patient:

ID#:

DOB:

Patient Address:

Drug Being Considered: _____

Please complete the following questions and sign below. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the medical diagnosis of this patient? *(Please do not use codes.)* _____

2. What other medications have been tried and not worked effectively? _____

3. How long do you anticipate this treatment to last? _____
4. Will this medication be provided and administered in physician's office? Yes No
- OR**
5. Will the member purchase from a participating pharmacy and self-administer? Yes No

Supporting medical documentation must be submitted.

Physician's Signature

Date

Please **Print** Name

Fax Number

Please **Print** Physician's Specialty

Phone Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.arbcs.com/providers/PharmacyForms.aspx