HIGHMARK WESTERN NEW YORK

Child Health Plus

Pharmacy Prior Authorization Form

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) partners with Amerigroup companies to administer certain services to Medicaid Managed Care (MMC) and Child Health Plus (CHPlus) members. Please note, this information is specific to the CHPlus program only.

Instructions:

1. Complete this form in its entirety. Any incomplete sections will result in delayed processing.
2. We review requests for prior authorization based on medical necessity only. If we approve the request, payment is still subject to all general conditions of Highmark BCBSWNY, including current member eligibility, other insurance, and program restrictions. We will notify the provider and the member's pharmacy of our decision.
3. To help us expedite your authorization requests, please fax all the information required on this form to **844-490-4877**. Allow us at least 24 hours to review this request. If you have questions regarding a pharmacy prior authorization request, call us at **866-231-0847**. The pharmacy may dispense up to a 72-hour supply while awaiting the outcome of this request. Please contact the member's pharmacy.
4. Access our **website** to view the *Preferred Drug List*.
5. An ICD/diagnosis code is required for all requests. A HCPCS billing code is required for all medical injectable/oncology requests billed as a medical claim. If the billing facility is different from the requesting physician, you will need to complete the billing facility information.

Member information

Last name, first name, middle initial:				
Highmark BCBSWNY ID #:			DOB:	
Sex (select one): ☐ F ☐ M	Height:		Weight:	
Administration site: ☐ Home ☐ Office ☐ Outpatient facility			Member's place of residence: ☐ Home ☐ Nursing facility	

Medication information

Drug name and strength requested:			
SIG (dose, frequency and duration):			
HCPCS billing code:		ICD code:	
Diagnosis and/or indication:			

Has the member tried other medications to treat this condition?

☐ Yes — Provide this information in the area below. You may be asked to provide supporting documentation such as: • Copies of medical records. • Office notes. • Complete *FDA MedWatch* form.	☐ No — Explain why not:
Drug(s) name and strength:	
Date range of use:	
SIG: (dose and frequency):	
Did the member experience any of the below? ☐ Adverse reaction ☐ Inadequate response ☐ Other	

https://providerpublic.mybcbswny.com

NYWEST-CD-019720-23 March 2023

Briefly describe details of adverse reaction, inadequate response, or other:
Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:
Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:
Other pertinent information:

Diagnostic studies and/or laboratory tests performed: List all tests done within the past 30 days that are related to diagnosis of medication requested.

Labs			**Diagnostic tests**		
Test	**Date**	**Result**	**Procedure**	**Date**	**Result**

Prescriber information

Last name, first name and middle initial:					
NPI # (required):			DEA/license #:		
Address where service was rendered:					
City:		State:		ZIP code:	
Telephone #:			Fax number #:		
Office contact name:			Contact direct phone #:		

Billing facility information

Name:					
NPI # (required):			DEA/license #:		
Address:					
City:		State:		ZIP code:	
Telephone #:			Fax number #:		
Office contact name:					

Pharmacy information

Name:		Pharmacy NPI #:	
Telephone #:		Fax #:	

Signature: I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission or concealment of material may be subject to civil or criminal liability.

Prescriber's signature (or authorized representative):	
Date:	