HIGHMARK WESTERN NEW YORK

Medicaid Managed Care
Child Health Plus

Prior Authorization Form — Medical Injectables

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 MMC and CHPlus programs only.

Note, if the following information is not complete, correct, and/or legible, the prior authorization (PA) process may be delayed. Use one form per member.

PA criteria can be found on our provider website, **https://providerpublic.mybcbswny.com**.

Member information		
Last name:		**First name:**
ID number:		**DOB:**
☐ Male ☐ Female	**Height:**	**Weight:**
Place of residence: ☐ Home ☐ Nursing facility		
Administration location: ☐ Home ☐ Office ☐ Outpatient facility		

Prescriber information	
Last name:	**First name:**
NPI #:	**TIN:**
Phone:	**Fax:**
Address where service rendered:	
City, State ZIP:	
Office contact name:	
Contact direct phone number:	

Billing facility information	
Facility name:	
NPI #:	**DEA #:**
Contact person name:	
Phone:	**Fax:**
Facility address:	
City, State ZIP:	

Medication information			
Drug name and strength requested:			
HCPS billing code:		**ICD code:**	
Has the member tried other mediations to treat this condition?			
☐ Yes	**If yes, please provide specifics:**		

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	Note, you may be asked to provide supporting documentation such as copies of medical records, office notes, and complete *FDA MedWatch Form*.	
	Drug(s) name and strength :	
	Date range of use :	
	SIG (dose and frequency):	
	Did member experience any of the below? ☐ Adverse reaction ☐ Inadequate response ☐ Other	**Briefly describe details of adverse reaction, inadequate response, or other:**
☐ No	**If no, please explain why not:**	

Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:

List all current medications, including dose and frequency:

Diagnostic studies and/or laboratory tests performed

List all tests done within the past 30 days that are related to diagnosis for medication requested.

Labs:

Test:	**Date:**	**Result:**

Diagnostic tests:		
Procedure:	**Date:**	**Result:**
By signing, the prescriber confirms the above information is accurate and verifiable by patient records and understands that any falsification, omission, or concealment of material may be subject to civil or criminal liability.		
Prescriber signature:		
Date:		

Fax this form to **844-493-9206**. For PA requests by phone or if you have questions, call Provider Services at **866-231-0847**.

Please allow Highmark BCBSWNY at least 24 hours to review this request.