

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 info	rmation						
Last name:				First name:			
ID number:			DOB:				
☐ Male ☐ Fe	Male □ Female Height:			Weight:			
Place of resid	dence: 🗆 Home	□ Nursir	ng facility				
Administration location: ☐ Home ☐ Office ☐ Outpatient facility							
Prescriber in	formation						
Last name:				First name:			
NPI #:				TIN:			
Phone:				Fax:			
Address whe	re service rend	ered:					
City, State ZI	P:						
Office contact	t name:						
	ct phone numbe	er:					
Billing facility	y information						
Facility name):						
NPI #:				DEA #:			
Contact person name:							
Phone:				Fax:			
Facility address:							
City, State ZIP:							
Medication in	nformation						
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:						

https://providerpublic.mybcbswny.com

Amerigroup Partnership Plan, LLC provides management services for Highmark Blue Cross Blue Shield of Western New York's managed Medicaid. Amerigroup Partnership Plan, LLC brinda servicios administrativos para Medicaid administrado de Highmark Blue Cross Blue Shield of Western New York

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Highmark Blue Cross Blue Shield of Western New York Medicaid Managed Care | Child Health Plus Prior Authorization Form — Medical Injectables Page 2 of 3

	Note, you may be asked to provide supporting documentation such as copies of medical records, office notes, and complete <i>FDA MedWatch Form</i> .						
	Drug(s) name and strength :						
	Date range of use :						
	SIG (dose and frequency):						
	Did member experience any o	of Briefly de	Briefly describe details of adverse				
	the below?	reaction, i	inadequate response, or other:				
	☐ Adverse reaction						
	☐ Inadequate response						
	☐ Other						
□ No	If no, please explain why not:						
Doscribo mo	dical necessity for nonpreferre	d modication(s)	or for proscribing outside of				
FDA labeling		u medication(s)	or for prescribing outside of				
DA labeling	,						
List all curre	nt medications, including dose	and frequency:	•				
Diagnastic	tudiaa audian labanatanu taata u						
	tudies and/or laboratory tests p done within the past 30 days th		a diagnosia for modication				
requested.	done within the past 30 days to	iai are reialeu i	o diagnosis for medication				
requesteu.							
Labs:							
Test:	D	ate:	Result:				

Highmark Blue Cross Blue Shield of Western New York Medicaid Managed Care | Child Health Plus Prior Authorization Form — Medical Injectables Page 3 of 3

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.