Prior Authorization Form – Medical Injectables

Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHPlus), and Essential Plan members. Please note, this information is specific to the MMC, HARP, CHPlus, and Essential Plan 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, **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 BCBS at least 24 hours to review this request.

Email is the quickest and most direct way to receive important information from Highmark Blue Cross Blue Shield.

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the right or via our online form (**https://bit.ly/signup-hm-ny**).