



**Independence  
Blue Cross**

## General Prior Authorization Form

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Gender Edit     
  Quantity Edit     
  Age Edit     
  Prior Authorization

**Drug Requested** \_\_\_\_\_  
(one drug per form only)

Quantity \_\_\_\_\_  
(qty. edit only)

Date: \_\_\_\_\_

Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Provider NPI: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Office Fax #: \_\_\_\_\_

Office Phone: \_\_\_\_\_

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

**\*\*\*MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE\*\*\***

**1. PROVIDER SPECIALTY** (specify all) \_\_\_\_\_

**2. DIAGNOSIS FOR DRUG REQUESTED** (specify all) \_\_\_\_\_

**3. MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

Drug Name (dose and frequency)	Duration of therapy (include dates)	Currently prescribed	Compliant
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

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**FAX: (888) 671-5285 or EMAIL: [FSS\\_Standard\\_Medicare@catalystrx.com](mailto:FSS_Standard_Medicare@catalystrx.com)**

**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**