BlueCross BlueShield of Louisiana

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P.O. Box 98031 • Baton Rouge, Louisiana • 70898-9031

CONFIDENTIAL PATIENT INFORMATION

EXPRESS SCRIPTS® Charting the Future of Pharmacy

DRUG AUTHORIZATION FORM

Phone: 800-842-2015 Fax: 877-837-5922

PATIENT DATA	Last Name	First Name	Policy Number	Date of Birth	Age
REQUESTING PHYSICIAN DATA	Last Name	First Name	Contact Name	Fax Number ( )	

BCBSLA Provider Number	Area of Practice/Specialty	Name of Place of Treatment	Treatment Ctr Provider #	Phone Number ( )

Billing Data	Diagnosis Code(s) (ICD-9): 1) 2)	CPT-4/HCPCS Code	Other Codes

REQUESTED DRUG INFORMATION

Indication/Diagnosis	**Drug Name**	**Strength/Dose/Directions**	**Anticipated Start Date and Length of Therapy**

THIS REQUEST REPRESENTS: ☐ Initial Therapy ☐ Re-authorization/Continuation of Therapy

PERTINENT LAB INFORMATION

CrCL:_____ ml/min	Hemoglobin:_____ g/dL	Test Date:_____
T-Score:_____	Hematocrit:_____ %	Test Date:_____
Triglyceride:_____mg/dL	Transferrin Saturation:_____%	Test Date:_____
Other:_____	Ferritin:_____ ng/mL	Test Date:_____
	Other:_____	

Pre-treatment Serum IgE level:_____ IU/ML Test Date:_____ Patient weight:_____ kg Date wt obtained:_____ Other:_____	FEV1/PEF Predicted Value:_____% PEF Variability:_____% Other:_____

CLINICAL INFORMATION

Prior Medications (Name, strength, and frequency) (Attach additional pages if needed)	**Adverse Reaction**	**Treatment Failure**	**Date Started**	**Length of Therapy**
	☐	☐		
	☐	☐		
	☐	☐		

If applicable, is there clinical evidence or patient history that suggests a step 1 medication will be ineffective or cause an adverse reaction to the patient? ☐ Yes ☐ No

If so, please explain:_____

List any other relevant clinical info if applicable:_____

_____

_____

_____

☐ Yes ☐ No Will the patient be receiving the drug in the physician's office? If no, **list name** of servicing provider/facility:

_____

PHYSICIAN SIGNATURE	**DATE**
_____ **Prescribing Physician**	_____

Note: On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. We recommend you contact BCBSLA at 800-922-8866 to verify benefits. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.