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Medicare Part D Prescription Coverage Request Form

View our formulary on line at https://www.blueshieldca.com/med_formulary

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information

Important Note: Expedited Decisions

If the standard decision time of 72 hours or less may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, an expedited (fast) decision can be requested.

☐ CHECK THIS BOX IF A DECISION NEEDS TO BE GIVEN WITHIN 24 HOURS.

Date of Request:

Physician Information	**Patient Information**
Physician's Name: ☐ PCP; ☐ Specialist: _____ Office contact:_____ Phone#: ( ) Facsimile #: ( )	Patient's Name: Patient's Address: Blue Shield ID#: Birthdate: Patient's height/weight: Drug Allergies:

DRUG REQUESTED:	QUANTITY:
STRENGTH:	DIRECTIONS:

DIAGNOSIS:	ICD-10 CODE:	EXPECTED LENGTH OF THERAPY:

PATIENT CLINICAL INFORMATION

1. Is this a new prescription? ☐ Yes ☐ No. If no, please provide date therapy was started.

An Independent Member of the Blue Shield Association

FAX form to: 1(888)697-8122 | **Pharmacy Services Phone #: 1(800)535-9481**

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2. Additional information we should consider *(attach any supporting documents)*:

Provider Signature:	**Date:**

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