

**Medicare Part D Prescription Coverage Request Form**

View our formulary on line at [https://www.blueshieldca.com/med\\_formulary](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: <input type="checkbox"/> PCP; <input type="checkbox"/> Specialist: _____	Patient's Name:
Office contact: _____	Patient's Address:
Phone#: (        )	Blue Shield ID#:
Facsimile #: (        )	Birthdate:
	Patient's height/weight:
	Drug Allergies:

DRUG REQUESTED:	QUANTITY:
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STRENGTH:	DIRECTIONS:
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DIAGNOSIS:	ICD-10 CODE:	EXPECTED LENGTH OF THERAPY:
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**PATIENT CLINICAL INFORMATION**

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

**FAX form to: 1(888)697-8122**

**Pharmacy Services Phone #: 1(800)535-9481**

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Thank you for your help in maintaining appropriate confidentiality.

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

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Provider Signature:

Date:

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