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| Medicare Part D Prescription Coverage Request Form - <INSERT DRUG CLASS or DRUG NAME> | | | | |
| View our formulary on line at <<https://www.blueshieldca.com/promise/medicare>> | | | | |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Patient’s Name:  Patient’s Address: | | |
| Office contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Blue Shield ID#: | | |
| Phone#: ( ) | | Birthdate: | | |
| Facsimile #: ( ) | | Patient’s height/weight: | | |
|  | | Drug Allergies: | | |
| [*Insert if PA is for a drug class:* DRUG(S) REQUESTED:]  [*If applicable, insert drugs with selection boxes:*   <drug>] | <QUANTITY or QUANTITY/MONTH>: | | | EXPECTED LENGTH OF THERAPY: |
| <STRENGTH or DOSE or STRENGTH/FORMULATION AND ROUTE OF ADMINISTRATION>: | DIRECTIONS: | | | |
| [*If applicable insert:* DIAGNOSIS:  <insert diagnosis selections>]  Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes.  **(**If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known) | | | | [*If applicable insert:* ICD-10 CODE(S):] |
| [*If applicable insert:* OTHER RELAVENT DIAGNOSES] | | | | [*If applicable insert:* ICD-10 CODE:] |
| **PATIENT CLINICAL INFORMATION** | | | | |
| [*Insert patient clinical information/questions required specific to the drug or drug class request.*] | | | | |
| **Provider Signature:** | | | **Date:** | |