BlueCross BlueShield of North Carolina | HealthyBlue

Standard Drug Prior Authorization Form

Member Information		
1. Member last name:	2. Member first name:	
3. Member ID #:	4. Member date of birth:	5. Member gender:
Prescriber Information		
6. Prescribing provider NPI#:		
7. Requester contact information		
Prescriber name:		
Address:	City:	State:
Zip code:	Fax:	
Phone:	Ext:	
Drug Information		
8. Drug name:	9. Strength:	
10. Quantity per 30 days:	11. ICD code:	
12. SIG (dose, frequency and duration):		
13. Length of therapy (in days): ☐ up to 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days ☐ Other:		
Clinical Information		
1. ☐ Failed two preferred drug(s). If only one preferred drug is available, then failed one preferred drug.		
List preferred drugs failed:		
1a. ☐ Allergic Reaction 1b. ☐ Drug-to-drug interaction. Please describe reaction:		
2. ☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:		
3. ☐ Clinical contraindication, co-morbidity, or unique member circumstance as a contraindication to preferred drug(s).		
Please provide clinical information: 4. ☐ Age specific indications. Please give member age and explain:		
5. ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference:		
6. ☐ Unacceptable clinical risk associated with therapeutic change. Please explain:		
Signature of prescriber:	Date:	
(Prescriber signature mandatory) I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.		

Fax this form to **844-376-2318**

Healthy Blue Pharmacy Prior Authorization Call Center: **844-594-5072**

https://provider.healthybluenc.com

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