Pharmacy Prior Authorization Form

Anthem Blue Cross and Blue Shield | Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging

Instructions:

1. Complete this form in its entirety. Any incomplete sections will result in a delay in processing.
2. We review requests for prior authorization (PA) based only on whether the request is medically necessary. If we approve the request, payment is still subject to all general conditions of Anthem Blue Cross and Blue Shield, including current member eligibility and other health insurance and program restrictions. We will notify you and the member's pharmacy of our decision.
3. To help us expedite your authorization requests, please fax all the information required on this form to **844-864-7860**.
4. Allow us at least 24 hours to review this request. If you have questions regarding your PA request, call us at **844-533-1995** for members enrolled in Healthy Indiana Plan, **844-284-1798** for members enrolled in Hoosier Care Connect, **866-408-6132** for members enrolled in Hoosier Healthwise, and **833-569-4739** for Indiana PathWays for Aging. The pharmacy is authorized to dispense up to a 72-hour supply while awaiting the outcome of this request. Please contact the member's pharmacy.
5. Access our website at providers.anthem.com/in to view the *Preferred Drug List*.
6. An ICD-10-CM diagnosis code is required for all requests. An HCPCS billing code is required for all medical injectable/oncology requests. If the billing facility is different from the requesting physician, the billing facility information will need to be completed.

Member information

Last name:		**First name:**		**Middle initial:**	
Member ID:		**Date of birth:**		**Sex:**	☐ Female ☐ Male
Member's place of residence:	☐ Home ☐ Nursing facility	**Administration site:**		☐ Home ☐ Office ☐ Outpatient facility	
Height:		**Weight:**			

Medication information

Drug name and strength requested:		**SIG (dose, frequency, and duration):**		**HCPCS billing code:**	
Diagnosis and/or indication:		**ICD-10-CM code:**			

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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Has the member tried other medications to treat this condition? ☐ Yes, provide this information in the area to the right. You may be asked to provide supporting documentation such as: • Copies of medical records. • Office notes. • A completed *FDA MedWatch form*. ☐ No, explain why not in the space below: _____ _____ _____ _____ _____ _____	**Drug(s) name and strength:**		
	Date range of use:		**SIG (dose and frequency):**
	Did the member experience any of the below? ☐ Adverse reaction ☐ Inadequate response ☐ Other Briefly describe details of the adverse reaction, inadequate response, or other in the space provided below: _____ _____ _____ _____ _____		

Describe the reason nonpreferred medication(s) or prescribing outside of FDA labeling is medically necessary:	
List all current medications including dose and frequency:	
Other pertinent information:	

Diagnostic studies and/or laboratory tests performed

List all tests done within the past 30 days that are related to the diagnosis or the medication requested.

Labs			Diagnostic tests		
Test	**Date**	**Result**	**Procedure**	**Date**	**Result**

Prescriber information

Last name:		**First name:**		**Middle initial:**	
NPI (required):		**DEA/license number:**			
Street address where service was rendered:					
City:		**State:**		**ZIP:**	
Phone number:		**Fax number:**			

Office contact name:		Contact direct phone number:	

Billing facility information

Name of facility:					
NPI/tax ID (required):		DEA/license number:			
Street address:					
City:		State:		ZIP:	
Phone number:		Fax number:			
Office contact name:					

Pharmacy information

Name of pharmacy:		Pharmacy NPI:	
Phone number:		Fax number:	

Authorization requested by

☐ Prescriber	☐ Pharmacy

Signature

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 may be subject to civil or criminal liability.

_____ _____

Prescriber signature (or authorized representative) Date