Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

Pharmacy Prior Authorization Form

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 **1-844-864-7860.**
4. Allow us at least 24 hours to review this request. If you have questions regarding your PA request, call us at **1-844-533-1995** for members enrolled in Healthy Indiana Plan, **1-844-284-1798** for members enrolled in Hoosier Care Connect and **1-866-408-6132** for members enrolled in Hoosier Healthwise. 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 **www.anthem.com/inmedicaiddoc** to view the *Preferred Drug List*.
6. An ICD-10 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 MI	Member ID	Date of birth	Sex (circle one) F M
Member's place of residence: ☐ Home ☐ Nursing facility Administration site: ☐ Home ☐ Office ☐ Outpatient facility	Height	Weight	

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Medication information

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

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 MI		NPI (required)	DEA/license #
Address where service was rendered		City	State
ZIP code	Phone number ( )	Fax number ( )	
Office contact name		Contact direct phone number	

Billing facility information

Name		NPI/tax ID (required)	DEA/license #
Address		City	State
ZIP code	Phone number ( )	Fax number	Office contact name

Pharmacy information

Name	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