Anthem Blue Cross and Blue Shield Healthcare Solutions
Medicaid Managed Care

Prior Authorization Form: Medical Injectables

Fax this form to **844-490-4876**. If you have telephone prior authorization requests or questions, call **844-396-2330**. Allow Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) at least 24 hours to review this request:

- Please indicate below whether this patient is step therapy exempt due to stage 3 or 4 cancer per *NV SB290*.
- Please indicate below whether pursuant to NRS 422.403, I request exemption from step-therapy for FDA-approved drugs for treating psychiatric conditions. I am one of the following prescribers: a psychiatrist; a physician assistant under the supervision of a psychiatrist; an APRN having psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or a primary care provider in consultation with any of the above.

Member information

First Name	Last Name	MI

Anthem ID:							
DOB:		Height:		Weight:		Sex:	☐ Male ☐ Female
Place of residence:	☐ Home ☐ Nursing facility						
Administration site:	☐ Home ☐ Outpatient facility ☐ Office						

Prescriber information

First Name	Last Name	MI

Tax ID:		NPI (required):	
Phone number:		Fax number:	
Address where service was rendered:			
City:	State:	ZIP code:	
Office contact name:			
Contact direct phone number:			

Billing facility information

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

Medication information

Drug name and strength requested:	
SIG (dose, frequency, and duration):	
HCPCS billing code:	

https://providers.anthem.com/nv

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Diagnosis and/or indication:	
ICD code:	
Has the member tried other medications to treat this condition? ☐ Yes ☐ No	
If **yes**, provide the following information:	
Drug name and strength:	
Date range of use:	
SIG (dose and frequency):	
Did the member experience the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other Briefly describe details of adverse reaction, inadequate response, or other in space provided below: You may be asked to provide supporting documentation such as copies of medical records, office notes, complete *FDA MedWatch* form, etc.	
If **no**, explain why not:	
Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:	
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 related to the diagnosis of the medication requested.

Labs:					
Test:		Date:		Result:	
Test:		Date:		Result:	
Test:		Date:		Result:	
Diagnostic tests:					
Procedure:		Date:		Result:	
Procedure:		Date:		Result:	
Procedure:		Date:		Result:	

Please submit separate authorizations for durable medical equipment, medical supplies, or home health nursing, found here:
https://providers.anthem.com/docs/gpp/NV_CAID_PrecertRequestForm.pdf

Signature
I certify the information provided is accurate and complete to the best of my knowledge, and I understand any falsification, omission, or concealment of material may be subject to civil or criminal liability.

Prescriber's signature (or authorized representative) Date