Anthem Blue Cross and Blue Shield Healthcare Solutions
Medicaid Managed Care

Pharmacy Prior Authorization Form

Instructions:

- Complete this form in its entirety. Any incomplete sections will result in a delay in processing.
- We review requests for prior authorization (PA) based on medical necessity only. If we approve the request, payment is still subject to all general conditions of Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) including current member eligibility, other insurance, and program restrictions. We will notify the provider and the member's pharmacy of our decision.
- To help us expedite your Medicaid authorization requests, please fax all the information required on this form to **844-490-4874**.
- Allow us at least 24 hours to review this request. If you have questions regarding a Medicaid PA request, call us at **844-396-2330**. 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.
- Access our website at **https://providers.anthem.com/nv** to view the *Preferred Drug List*.
- An ICD/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.

Please indicate whether this patient is Step Therapy exempt due to stage 3 or 4 cancer per *NV SB290*. 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			

Medication information

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

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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:	
Diagnostic tests:					
Procedure:		Date:		Result:	
Procedure:		Date:		Result:	

Prescriber information

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

Pharmacy information

Name:	Pharmacy NPI:
Phone number:	Fax number:

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