Anthem BlueCross BlueShield

BadgerCare Plus

Prior Authorization Form for Medical Injectables

If the following information is not complete, correct and/or legible, the prior authorization (PA) process can be delayed. Use one form per member.

Member information

Last name ______________ **First name** ______________

Member ID number ______________ **Date of birth** __ __ - __ __ - __ __ __ __

Member information
****Required****
☐ **Male** ☐ **Female** **Height** ___________ **Weight**_________
Member's place of residence: ☐ Home ☐ Nursing facility
Administration location: ☐ Home ☐ Office ☐ Outpatient facility

Prescriber information

Last name ______________ **First name** ______________

NPI ______________ **Tax ID** ______________

Phone ___ - ___ - ____ **Fax** ___ - ___ - ____

Prescriber information/demographics		
Address where service was rendered:	**City:**	**State:**
ZIP code:	**Office contact name:**	**Contact direct phone number:**
Is the address above also the billing address? ☐ **Yes** ☐ **No** (If no, please complete the section below.)		

Billing facility information

Facility name ______________

NPI ______________ **DEA #** ______________

Contact person for billing facility

Last name ______________ **First name** ______________

Phone ___ - ___ - ____ **Fax** ___ - ___ - ____

Medication information		
Drug name and strength requested:	**SIG (dose, frequency and duration):**	**HCPCS billing code:**
Diagnosis and/or indication:		**ICD code (required):**

https://mediproviders.anthem.com/wi

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Has the member tried other medications to treat this condition?

☐ Yes. Please 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 or a completed FDA MedWatch form.

☐ No. Explain why not:

____

____

____

____

____

____

Drug(s) name and strength:

Date range of use:

SIG (dose and frequency):

Did 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 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 that are related to the diagnosis or the medication requested.)

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

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 (required):______________________________ **Date:**_________

Providers who are contracted with Anthem Blue Cross and Blue Shield (Anthem) 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.

Fax this form to 1-844-512-7024.

For telephone PA requests or questions, please call Provider Services at 1-855-558-1443.

Please allow Anthem Blue Cross and Blue Shield at least 24 hours to review this request.