Part B Drug Prior Authorization Request Form

Certain requests for coverage require review with the prescribing physician.
Please:

- Complete this form and fax or call the number listed.
- Note any information left blank or illegible may delay the review process.
- Use one form per prior authorization request.

Fax: 1-904-357-6699
Phone: 1-904-357-3900, Ext. 89277

REQUEST TYPE:

☐ Standard Review (72 hours).

☐ Expedited Review (24 hours). By checking this box, I certify application of the 72-hour standard review timeframe could seriously jeopardize the member's health or life or their ability to regain maximum function.

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
Name:		Name:	
ID Number:		Specialty:	
Date of Birth:		NPI/DEA Number:	
Address:		Facility Name & Address:	
Phone Number:		Office Contact Name:	
Weight:		Phone Number:	
Height:		Fax Number:	

III. MEDICATION REQUESTED

Drug Name:	
Directions/SIG (**dose, route,** and **frequency**):	Dose: Route: Frequency:
HCPCS/J-Code & modifier:	
Start date of therapy:	
If continuing therapy, include Florida Blue prior approval	Prior Florida Blue approval Cert #:

IV. DRUG DISPENSING AND ADMINISTRATION

Where drug will be administered:
☐ Physician's office
☐ Outpatient hospital: Name: ______________________________
☐ Inpatient hospital: Name: ______________________________
☐ *Home ☐ Other: ___________________________________

If drug is **administered in healthcare professional setting**:
Will the provider be buying and billing or will drug be procured from specialty pharmacy*?
☐ Buy and bill
☐ Specialty pharmacy*
(*only participating pharmacy is CVS/Caremark; otherwise obtain via Part D benefit)

Note: If member is picking up drug at a pharmacy, must submit request for Part D coverage.

V. ADDITIONAL CLINICAL INFORMATION

ICD-10 Code:	
Diagnosis:	

Is the medication being requested for use in an ongoing investigational trial? ☐ YES ☐ NO

VI. MEDICATION HISTORY (for this diagnosis)

List therapeutic alternatives previously and currently used with start/end dates and outcomes:

	Drug Name, Strength, and Dosage	Dates of Therapy (start/end dates)	Reason for Discontinuation
1			
2			
3			

Note: Step therapy is required, and the definition of medical necessity must be met, for certain higher-cost non-preferred medications: https://www.floridablue.com/providers/medical-pharmacy-info/part-b-step-therapy

PRESCRIBER NAME & SIGNATURE **DATE/TIME**

VII. PERTINENT CLINICAL INFORMATION

Clinical information is required for a determination. Missing information and lack of prompt response to requests for additional information may delay response time. **Please attach** pertinent medical history, progress notes, laboratory, and diagnostic test results which may support approval. Any additional notes can be included below and on the next page.

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Notes: