BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

CONTROLLED SUBSTANCE COVERAGE AUTHORIZATION REQUEST FORM

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

PATIENT INFORMATION

☐ Prior Authorization ☐ Step Therapy Exception ☐ Appeal ☐ Quantity Limit Exception

Patient Name

Date of Birth (mm/dd/yyyy)

Patient's Home Address

Contract Number (include prefix)

City | State | Zip

PHYSICIAN INFORMATION

Physician Name

Practice Type
☐ PCP ☐ Specialty: _____

Practice Address

Physician NPI

City | State | Zip

Provider Number

Office Phone | Office Fax

REQUEST TYPE *(please check one)*

☐ Initial Authorization ☐ Authorization Renewal *(Please attach any additional medical information.)*

TREATMENT INFORMATION

Drug/Strength/Frequency/Quantity Requested:

Diagnosis/ ICD-9 Codes: | Duration of Disease (yrs):

Medical rationale for use (include chart notes if possible):

List medications this patient has tried for this condition (include current medications and titration history if applicable)

	Drug	Strength/Frequency	Dates of Therapy	Outcome of Therapy
1.				
2.				
3.				
4.				
5.				

Does this patient have any co-morbid conditions that will affect therapy: ☐ Yes ☐ No

If so, please list: _____

I certify this information is complete and correct to the best of my knowledge.

Physician SIgnature _____ Date _____

Please attach any additional medical justification

SUBMISSION INSTRUCTIONS

FAX

You may fax the signed and completed form to Pharmacy Review at:
866 606-6021

MAIL

You may mail the signed and completed form to:

Pharmacy Review
Post Office Box 3210
Auburn, AL 36831