Kansas City BLUE MEDICARE ADVANTAGE

**Complete form in its entirety and fax to 816-398-6547, attention PA pharmacist.**
Contact Blue Medicare Advantage Medical Management Department at 1-(866)-508-7140 if you have questions.

**PART B DRUG PRIOR AUTHORIZATION REQUEST FORM**

**Request type:**

☐ Standard Review (72 hour)

☐ Expedited Review (24 hours) – By checking this box I certify that applying the 72 hour standard review timeframe might seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**NOTE: Please complete all fields in the form. Missing information and lack of prompt response to requests for additional information may delay response time. Please attach relevant supporting documentation such as labs, results of diagnostic tests, and office visit notes to this request.**

**PATIENT INFORMATION**

| Patient name | | | DOB | |
|---|---|---|---|---|
| Street address, city, state, zip | | | | |
| Blue Medicare Advantage member ID# | Sex M F | Weight | Height | BMI |
| Drug allergies | | | | |

**PRESCRIBER INFORMATION**

| Prescriber name | Office contact person and direct extension |
|---|---|
| Street address, city, state, zip | |
| Office phone | Office fax |

**DRUG DISPENSING AND ADMINISTRATION INFORMATION**

| Who is furnishing the drug? | Facility where drug is to be administered |
|---|---|
| ☐ Physician's office or facility will furnish drug<br>☐ Member picking drug up at a pharmacy.<br>IMPORTANT NOTE: If member is picking drug up at pharmacy, this request must be faxed to the Part D drug prior authorization department at 1-858-790-7100. | ☐ Physician's office<br>☐ Outpatient infusion center<br>Center name: _____<br>☐ Home Infusion<br>Agency name: _____<br>☐ Self-inject |

| **MEDICATION** | |
|---|---|
| Name of requested medication, dose, route, frequency | |
| ☐ New start ☐ Continued treatment | Next treatment date |

| **DIAGNOSIS AND CLINICAL INFORMATION PLEASE DOCUMENT ICD-10 HERE:** |
|---|
| Please provide the diagnosis: |
| Please include an explanation for the request below. **IN ADDITION, PLEASE ATTACH ANY RELEVANT SUPPORTING DOCUMENTATION SUCH AS LABS, RESULTS OF DIAGNOSTIC TESTS, AND OFFICE VISIT NOTES TO THIS FORM.** |

Prescriber signature_____Date_____