

**ACE/ARB, ARB/CCB, RENIN INHIBITOR  
 PREAUTHORIZATION REQUEST  
 PHYSICIAN FAX FORM**



**ONLY the prescriber may complete and fax this form.**

**Incomplete forms will be returned for additional information.** The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit [www.bcbsil.com](http://www.bcbsil.com)

**Today's Date:** \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:		City, State, Zip	Patient Telephone:

**INSURANCE INFORMATION**

BCBS ID Number:	Group Number:
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**PHYSICIAN/CLINIC INFORMATION**

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient's Diagnosis:
Medication Requested:
<p>1. Is the patient currently treated with the requested medication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, when was treatment with the requested medication started? _____</p> <p>2. Please list all reasons for selecting the requested <b>medication</b> over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____</p> <p>_____</p> <p>_____</p> <p>3. Please list all medications the patient has <b>previously tried and failed for treatment of this diagnosis.</b> (Please specify if the patient has tried brand-name products or generic products.) _____</p> <p>_____</p> <p>_____</p> <p>4. Please list any other medications the patient will use in <b>combination</b> with the requested medication for treatment of this diagnosis. _____</p> <p>_____</p> <p>_____</p>

**Please fax or mail this form to:**  
 Blue Cross and Blue Shield of Illinois  
 c/o Prime Therapeutics LLC, Clinical Review Department  
 1020 Discovery Road, No. 100  
 Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.480.8130      Phone: 800.285.9426**

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