

**ANABOLIC STEROID
PREAUTHORIZATION REQUEST
PHYSICIAN FAX FORM**



**BlueCross BlueShield
of Illinois**

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

PATIENT INFORMATION

Today's Date: _____

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 - ICD-9 code plus description:
Medication Requested: _____ Strength: _____
Dosing Schedule: _____ Quantity per Month: _____
1. If the patient's diagnosis is anemia, what is the patient's hematocrit? _____
2. Has the patient had significant weight loss following surgery, infection or trauma? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what has the percent weight loss been over the past 6 months? _____ %
3. Please indicate the patient's height _____ weight _____ and BMI _____
4. Has the patient been evaluated to rule out treatable causes of weight loss? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does the patient require long-term treatment with corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is the patient's testosterone level below the testing laboratory reference range? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. For female patients , is the patient postmenopausal? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many years postmenopausal? _____ years
8. Please list all other medications the patient is currently taking _____
9. Does the patient's medical history include any of the following? Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hyperlipidemia <input type="checkbox"/> Yes <input type="checkbox"/> No Renal disease <input type="checkbox"/> Yes <input type="checkbox"/> No Coronary artery disease (CAD) or atherosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No

Please fax or mail this form to:
Blue Cross and Blue Shield of Illinois
c/o Prime Therapeutics LLC, Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 **Phone:** 800.285.9426

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