

**BISPHOSPHONATES
 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

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 - ICD-9 code plus description:
Medication Requested:
Dosing Schedule: Quantity per Month:
1. Is the patient currently treated with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment started? _____
2. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions.) _____ _____
3. Please list all reasons for selecting the requested strength, dosing schedule and quantity over alternatives (e.g. lower dose has been tried.) _____ _____
4. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products or generic products.) _____ _____
5. Please list any other medications the patient will use in combination with the requested medication for treatment of this diagnosis. _____ _____

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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