

**NON-SEDATING ANTIHISTAMINES
STEP THERAPY 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: |
|-----------------|---------------|

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

| | |
|---|-----------|
| Medication Requested: | Strength: |
| <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. Has the patient previously tried generic fexofenadine or generic fexofenadine/pseudoephedrine combination? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____</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
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 Phone: 800.285.9426

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