

**ACE/ARB  
PREAUTHORIZATION REQUEST  
PHYSICIAN FAX FORM**



**BlueCross BlueShield  
of Illinois**

**ONLY the prescribing physician may complete and fax this form.**

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**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)

**Patient first name** \_\_\_\_\_ **Patient last name** \_\_\_\_\_

**Blue Cross ID number** \_\_\_\_\_ **Date of birth (MM/DD/YYYY)** \_\_\_\_\_

**Patient address** \_\_\_\_\_ **Patient phone** (\_\_\_\_\_) \_\_\_\_\_

Requesting physician \_\_\_\_\_

Physician specialty \_\_\_\_\_ Physician UPIN# \_\_\_\_\_ Physician NPI# \_\_\_\_\_

Physician signature \_\_\_\_\_ Date \_\_\_\_\_

Physician (clinic name) and address \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Patient diagnosis \_\_\_\_\_

**If you are requesting a brand name ACE inhibitor or ACEI/diuretic combination, please answer the following:**

1. What medication are you requesting? \_\_\_\_\_
2. Is the patient currently stable on the requested medication?  YES  NO  
If yes, how long has the patient been taking the requested medication? \_\_\_\_\_
3. Please include any additional information that should be considered for review of this request \_\_\_\_\_  
\_\_\_\_\_

**If you are requesting an ARB or ARB/diuretic combination, please answer the following:**

1. What medication are you requesting? \_\_\_\_\_
2. Has the patient previously tried and failed any ACEI or ACEI/diuretic combination?  YES  NO
3. Does the patient have contraindications to any ACEI or ACEI/diuretic combination?  YES  NO
4. Is the patient currently stable on the requested medication?  YES  NO  
If yes, how long has the patient been taking the requested medication? \_\_\_\_\_
5. Please include any additional information that should be considered for review of this request \_\_\_\_\_  
\_\_\_\_\_

**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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