



BlueShield of Northeastern New York

Preauthorization/Non-Formulary Medication Request Form

Fax (716) 887-8981 or toll-free fax 1-866-221-5784

Toll-free telephone 1-800-939-3751

BlueShield use only

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Date: \_\_\_\_\_

Patient name: \_\_\_\_\_

ID #: \_\_\_\_\_ DOB: / /

Diagnosis: \_\_\_\_\_

Medication requested: \_\_\_\_\_

Dosage and regimen prescribed: \_\_\_\_\_ Anticipated duration\*: \_\_\_\_\_

\*Maximum duration for approvals is one year, and may be less for acute care or at plan discretion.

Justification for request

(Where applicable, please list other medication, allergies, or therapeutic measures attempted and results; additional supporting documentation, such as lab reports and test results, should also be attached):

Medications tried:

Blank lines for justification and medications tried.

Prescriber name (please print): \_\_\_\_\_

Prescriber specialty: \_\_\_\_\_

Prescriber signature: \_\_\_\_\_

DEA #: \_\_\_\_\_

NPI: \_\_\_\_\_

Telephone #: ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_

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Pended (Information needed to complete request. our decision is pending your response):

Date pended request will close: \_\_\_\_/\_\_\_\_/\_\_\_\_

Blank lines for pended request details.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature: \_\_\_\_\_

Determination:  Denied  Approved Time period: \_\_\_\_\_

Reason: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature: \_\_\_\_\_

Approvals are valid only if person has active prescription drug coverage through BlueShield of Northeastern New York. This preauthorization is subject to all drug therapy guidelines in effect at the time of the approval and other terms, limitations or provisions in the member's contract/rider. We reserve the right to update and/or modify our drug therapy guidelines for prospective services.