P.O. Box 327, MS 432
Seattle, WA 98111-0327

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA
An Independent Licensee of the Blue Cross Blue Shield Association

Pharmacy Services Prior Authorization Request Form

Please allow 24 to 48 hours after we receive all the information for a response.
For Medical Policy information please visit our website at: **www.premera.com**

Please fax this back to Pharmacy Services

Fax Number	**Phone Number**
1-888-260-9836	**1-888-261-1756**

Patient Name:		ID Number:	
Date of Birth:		ICD code:	
Prescriber's Name:			MD/DO/ARNP/PA-C *(circle one)*
Fax Number:			
Prescriber's Address:			
Prescriber's Signature	*Date*	*Phone Number*	*Ext.*

Requested medication, CPT code, strength and dosing schedule

☐ By checking this box you are certifying that a brand name contraceptive is medically necessary

Diagnosis related to use:

Medications Tried

	Medication name	Strength	Dosing schedule	Therapy duration	Dates tried	Reason therapy stopped
1						
2						
3						
4						
5						

Additional pertinent information

****Please submit this fax-back sheet along with *relevant* chart notes to Pharmacy Services****

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information

Internal Use Only

☐ Approve/Fax

☐ Deny

Approved Time Period: ☐ _____ Months

Start Date _____ End Date _____

Date Approved _____ By _____

Unless specifically requested elsewhere in this document, please do **not** send a DNA or other genetic sample, or the results of any genetic typing, test or analysis, including DNA.