of Tennessee

# Pharmacy Medication Review Request

Fax Cover Form **1-888-343-4232**

**This is just the review request cover sheet. You need to submit additional medical information related to your review request along with this form.**

Please use this form for BlueCross BlueShield of Tennessee Commercial members ONLY.

All fields must be filled in for us to complete the review, otherwise we'll return this form which will delay the review process.

Please indicate the type of exception request (select all that apply):

☐ Non-Covered Drug ☐ Waive Copay ☐ Quantity Limit Exception ☐ Prior Authorization

Today's Date: _____ / _____ / _____ Number of pages including cover sheet: _____
MM / DD / YYYY

## Request for Expedited Review

☐ By placing a check mark here, I certify the standard review time may seriously jeopardize the life or health of the member or member's ability to regain maximum function. If this is an urgent request, please call 1-800-924-7141.

## Member Information (Required)

Last Name _____

First Name _____

BlueCross Member ID: _____

Address _____ State _____ Zip _____

Telephone Number _____

Date of Birth _____ / _____ / _____
MM / DD / YYYY

## Medication Information (Required)

Drug Name and Strength: _____

Directions for use: _____

Quantity per 30 days: _____

Date requested for approval of authorization to begin: _____ / _____ / _____
MM / DD / YYYY

**Continued on next page**

## Practitioner Information (Required)

Last Name/First Name: _____ NPI: _____

Office Fax No.: _____ Office Phone No.: _____

1. What is the diagnosis (including ICD-10 codes)?

2. Is this request for provider-administered or self-administered specialty medication?

   ☐ Provider-administered ☐ Self-administered

   *Note: for provider-administered prior authorization requests, please do not use this form. Call 1-800-924-7141.

3. Has the patient tried any other medications for this diagnosis?

   ☐ Yes ☐ No

4. Please list any previous or current drugs related to the patient's medical condition, including dates. You may attach a list if needed.

5. Do you have any additional clinical information pertinent to this request for coverage? If so, please attach medical records, office notes, or test results.

   ☐ Yes ☐ No

Additional Comments:

Provider (or Authorized) Signature: _____ Date: _____ / _____ / _____

MM / DD / YYYY