

Prior Authorization (PA) Request Form

To submit request electronically, please go to covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: 888-446-8535

Mail: Blue Cross NC, ATTN: Part D Coverage Determination
P.O. Box 17509, Winston Salem, NC 27116-7509

Call: 888-298-7552 Blue Medicare Rx
888-296-9790 Blue Medicare HMO/PPO

Incomplete Form May Delay Processing

Prescriber Information		Patient Information	
Physician Name:	NPI #:	Patient Name:	
Office Contact Person:		Patient ID #:	
Office Phone #:	Office Fax #:	Home Phone #:	
Address:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
City:	State:	Zip:	DOB:
Diagnosis and Medication Information			
Drug Requested:		Diagnosis Code:	
Strength and Route of Administration:		Dosing Schedule:	
Quantity per 30 Days:			
Please answer questions below			
<p>1. Is this request for an expedited review?.....<input type="checkbox"/> Yes <input type="checkbox"/> No Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. A standard review will have a decision made within 72 hours for a coverage determination.</p>			
<p>2. Please select the diagnosis for the requested drug and answer any associated questions:</p> <p><input type="checkbox"/> Myelofibrosis</p> <p style="margin-left: 20px;">A. Is the patient an adult?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">B. Does the patient have intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Other (please specify): _____</p>			
<p>3. Is the patient currently (within the past 180 days) being treated with the requested agent?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">A. If NO, does the patient have any FDA labeled limitations of use not otherwise supported in NCCN guidelines?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>4. Is the quantity requested <i>greater</i> than the set quantity limit #120 capsules per 30 days?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">A. If YES, please provide a clinical rationale in support of the quantity requested, including length of time the requested dose has been used (may submit medical records to support this request): _____</p> <p>_____</p>			
<p>I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.</p>			
Physician Signature: _____		Date: _____	

Blue Cross and Blue Shield of North Carolina is a HMO/PPO/PDP plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.