### Pharmacy Prior Authorization Request

(Commercial only - Please do not use for Medicare Advantage or Federal Employee Programs)

**CHECK IF:**
- [ ] Initial Authorization
- [ ] Concurrent Authorization and (If applicable) reference #: __________________

- Submission of this information by fax or phone does not constitute authorization of services. Blue Cross of Idaho's Health Care Operations department will notify you of its decision by fax, phone or via the portal on Blue Cross of Idaho providers.bcidaho.com.

- Please fax this completed form as well as all pertinent medical records documenting the clinical indications and/or medical necessity. Initial requests MUST include the Initial Assessment. Please allow 10 days for processing.

- Pharmacy Fax: 208-387-6969
- Medical Pharmacy Fax: 208-472-5164

**IF DELAYING SERVICE COULD SERIOUSLY JEOPARDIZE THE MEMBER’S LIFE, HEALTH OR ABILITY TO REGAIN MAXIMUM FUNCTION PLEASE HAVE MEDICAL PROVIDER SIGN AND DATE.**

This does not apply to scheduling issues. I, Dr. ___________________________ attest that the request for expedited prior authorization meets the criteria listed in PAP241, is documented and supported in the medical records.

**Expeditied Reason:** ___________________________ Physician Signature: ___________________________ Date: ___________________________

<table>
<thead>
<tr>
<th>Service and Procedure Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Servicing Company or Provider:</td>
</tr>
<tr>
<td>Office Address:</td>
</tr>
<tr>
<td>Contact Person:</td>
</tr>
<tr>
<td>Facility/Place of Service:</td>
</tr>
<tr>
<td>Facility Address:</td>
</tr>
</tbody>
</table>

**Medication Requests (to include Home IV, Enteral Therapy and Chemotherapy):**

Please refer to bcidaho.com for a current listing of medications requiring prior authorization

<table>
<thead>
<tr>
<th>Drugs Requested</th>
<th>CPT Code(s)</th>
<th>Dosage</th>
<th>Frequency of Dosage</th>
<th>Duration of Therapy</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information:** If medical necessity justifies special handling, please include explanation.

**Source of Documentation for OFF LABEL USE:** Select one OR attach entire peer reviewed journal article

- [ ] DrugDex
- [ ] NCCN
- [ ] ACCC
- [ ] Guidelines
- [ ] Compendium

Please fax this completed form as well as all pertinent medical records documenting the clinical indications and/or medical necessity. Initial request MUST include the Initial Assessment.

Questions? Call Blue Cross of Idaho 208-331-7535 or 800-743-1871

3000 E. Pine Ave. • Meridian, Idaho 83642 • 208-345-4550
Mailing Address: P.O. Box 7408 • Boise, ID 83707-1408

© 2018 by Blue Cross of Idaho, an independent licensee of the Blue Cross and Blue Shield Association

Form No. 9-185NI (12-18)