Request for Outpatient Retail Pharmacy Prior Authorization

Fax to: Clinical Pharmacy Program (800) 583-6289 or Web: https://provider.express-path.com.

We plan to respond to your request within two business days of our receipt.

We cannot process requests unless they contain **all** of the information requested below:	
Patient Information (REQUIRED)	
Name	
BCBSMA ID number	
Is the patient a BCBSMA employee? If yes, please fax request to: **(617) 246-4013**	Yes No
Date of Birth	
Patient's Diagnosis or ICD-9-CM code	
Physician Information (REQUIRED)	
Name	
Medical Specialty	
BCBSMA Provider number/NPI number	
Telephone Number	
Fax Number	
Is this fax number 'secure' for PHI receipt/transmission per HIPAA requirements? (circle one) Yes No	
Contact Name (if different from physician)	
Please select **one** of the three following sections to complete, depending on the nature of your request for the above-named patient.	
Formulary Exception Request	
Name of non-covered drug you want to prescribe	
Reason for Individual Consideration Request (please check one): ___ Treatment failure with the following covered drugs in class:________________________________ ___ Documented adverse reaction to the following covered drugs:________________________________ ___ Other clinical reason (please specify) ____	
Quality Care Dosing Override Request	
Drug name, strength and quantity requested:	
Clinical reason for override (please specify)	
Outpatient Retail Pharmacy Prior Authorization Request	
Drug name:	
Start/End date (must be one year or less):	
Associated Co-morbid diagnosis:	
For Epogen®/Procrit® only:	GFR:
	Is patient certified ESRD with Medicare? Yes No
Prescriber Signature:	Date: