BlueCross BlueShield of Kansas

Clear Data

ACA PREVENTION COPAY WAIVER
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

BCBS Kansas REQUIRES that this form be completed by the prescriber. This form is for prospective, concurrent and retrospective reviews.

The following documentation is REQUIRED for prior authorization. Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit the Blue Cross and Blue Shield of Kansas website at http://www.bcbsks.com

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description**:**

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

For ALL Requests:

1. Is the patient currently treated with the requested medication? ..... ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Please list all reasons for selecting the requested **medication, dosing schedule, and quantity** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): _____
   _____
3. Please list all other medications the patient is **currently taking** for treatment of this diagnosis. _____
   _____
4. Please list all medications the patient has **previously tried and failed** for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.)
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____

For Statin Therapy:

5. Is the requested agent for use in the primary prevention of cardiovascular disease (CVD)? ..... ☐ Yes ☐ No
6. Does the patient have any of the following CVD risk factors? *(Check all that apply)*
   - ☐ Dyslipidemia
   - ☐ Diabetes
   - ☐ Hypertension
   - ☐ Smoking
7. Does the patient have a calculated 10-year risk of a cardiovascular event of 10% or greater based on calculations from the ACC/AHA ASCVD Risk Estimator? ..... ☐ Yes ☐ No

Blue Cross and Blue Shield of Kansas
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