ADHD MEDICATIONS
PREAUTHORIZATION REQUEST
PHYSICIAN FAX FORM

BlueCross BlueShield of Illinois

ONLY the prescriber may complete and fax this form.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcbsil.com

Today's Date: _____

PATIENT INFORMATION

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

INSURANCE INFORMATION

BCBS ID Number:	Group Number:

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician 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-9 code plus description:

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

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** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions.) _____

3. Please list all other medications the patient is **currently taking** for treatment of this diagnosis. _____

4. Please list any other 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.) _____

Please fax or mail this form to:
Blue Cross and Blue Shield of Illinois
c/o Prime Therapeutics LLC, Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 **Phone: 800.285.9426**