Pharmacy Prior Authorization Request Form

**Plan Information**

*Select Plan:*

- [ ] Regence BlueShield of Idaho
- [ ] Regence BlueCross BlueShield of Oregon
- [ ] RegenceRx
- [ ] Asuris Northwest Health
- [ ] Regence BlueShield (Washington)
- [ ] Regence BlueCross BlueShield of Utah

**Fax completed form to:**

Questions or Assistance:

**Patient Information**

*Last Name:______________  *First Name:______________  M.I.:_____

*Patient I.D.:__________  *Date of Birth:__________  *Patient Sex:_____

**Medication Information**

*Medication to Prior Authorize:

__________________________________________________________

Strength:_________  Quantity per Month:_________  Length of Therapy:_________  Currently Taking?_____

Directions:________________________________________________

Please list which medications the patient has tried for this diagnosis (include chart notes if possible):

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Date(s) Medication Was Used</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Patient Diagnosis:_____________________________________________________

Medical Rationale:____________________________________________________

_____________________________________________________________________

**Provider Information**

Provider Name - *Last:______________  *First:______________  Degree:_____

Street Address:

City, St, Zip:

*Phone Number:_________  *Fax Number:_________  Contact:_________

Pharmacy Name:________________________________________  Pharmacy Phone:

Provider Signature:________________________________________  Date:_________