DISPENSING LIMIT OVERRIDE
PRESCRIBER FAX FORM

BlueCross BlueShield of Oklahoma

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

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.bcbsok.com*. Start saving time today by filling out this prior authorization form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review

☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip		Patient Telephone:
BCBS 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:
Length of Therapy Requested:	

1. Is the patient currently treated with the requested dose of the requested medication? ..... ☐ Yes ☐ No

   If yes, when was treatment with the requested dose started? _____

2. Please list all reasons for selecting the **requested medication, strength, dosing schedule and quantity** over alternatives (e.g. contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried). _____

   _____

3. 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 or generic products.)

   _____ Date(s): _____ _____ Date(s): _____

   _____ Date(s): _____ _____ Date(s): _____

   _____ Date(s): _____ _____ Date(s): _____

4. Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. (Please include strength and quantity per month)

   _____ Quantity: _____ _____ Quantity:_____

   _____ Quantity: _____ _____ Quantity:_____

   _____ Quantity: _____ _____ Quantity:_____

Please continue on page 2.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For Samsca:

5. Has the patient had an additional hospitalization for hyponatremia and for initiation of Samsca? ..... ☐ Yes ☐ No
6. Have the patient's liver function tests been checked within the last 10 days? ..... ☐ Yes ☐ No
7. Is the patient's ALT within normal limits? ..... ☐ Yes ☐ No

For Antiemetic agents:

8. Is the patient receiving cancer chemotherapy? ..... ☐ Yes ☐ No

If yes, please provide chemotherapy regimen: _____

If yes, how many days per month is the patient receiving chemotherapy? _____

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

TOLL FREE
Fax: 877.243.6930 Phone: 800.991.5643

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