DISPENSING LIMIT OVERRIDE

PRESCRIBER FAX FORM

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 prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/star_kids_prior_auth.html

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

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	
BCBSTX 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 dose of the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested dose started? _____
   For topical agents, is the request for treatment of an area of the skin not previously treated? ☐ Yes ☐ No
2. Please list all reasons for selecting the requested **medication, quantity and dosing schedule** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose 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): _____
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:_____

For Benzodiazepine Agents:

5. Is the patient currently treated, within the past 30 days, with a different strength or another benzodiazepine medication at the same time as the requested medication? ☐ Yes ☐ No
   If yes, will the currently used benzodiazepine be stopped before starting the requested medication? ☐ Yes ☐ No
   If no, are the concomitant benzodiazepines being prescribed for use in a seizure disorder? ☐ Yes ☐ No

For Samsca:

6. Has the patient had an additional hospitalization for hyponatremia and for initiation of Samsca? ☐ Yes ☐ No
7. Does the patient need therapy for longer than 30 days for the intended diagnosis? ☐ Yes ☐ No
   ***Please submit documentation in support of the longer therapy.**
8. Have the patient's liver function tests been checked within the past 10 days? ☐ Yes ☐ No
   If yes, is the patient's ALT within normal limits? ☐ Yes ☐ No

Please continue to Page 2.

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

For Narcotic Analgesic or Opioid Dependence (e.g. Suboxone) Agents:

9. Does the patient have a diagnosis of chronic cancer pain due to an active malignancy? ☐ Yes ☐ No
10. Is the patient eligible for hospice care? ☐ Yes ☐ No
11. Has the prescriber provided documentation of a formal, consultative evaluation including diagnosis, a complete medical history which includes previous and current pharmacological and non-pharmacological therapy, and the need for continued opioid therapy has been assessed? ☐ Yes ☐ No

    ***Please note: Medical records including chart notes must be submitted.**
12. Has the prescriber confirmed that a patient-specific pain management plan is on file for the patient? ☐ Yes ☐ No
13. Has the prescriber confirmed that the patient is not diverting the requested medication, according to the patient's records in the state's prescription drug monitoring program (PDMP), if applicable? ☐ Yes ☐ No
14. Does the patient's medication history include a trial of at least 7 days of an immediate-acting opioid in the last 30 days? ☐ Yes ☐ No
15. Is the requested medication being used for post-operative pain management following a tonsillectomy and/or adenoidectomy? ☐ Yes ☐ No
16. Is the patient currently opioid tolerant? ☐ Yes ☐ No

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility Authorization does not guarantee payment.

Please fax or mail this form to:
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TOLL FREE

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