Part B Drug Prior Authorization Request Form

Florida Blue Your Health Solutions Partner | MEDICARE

Certain requests for coverage require review with the prescribing physician. Please:

- Complete this form, and fax or call the number listed.
- Note any information left blank or illegible may delay the review process.
- Use one form per prior authorization request.

Fax: 1-904-357-6699
Phone: 1-904-357-3900, Ext. 89277

REQUEST TYPE:

☐ Standard Review (72 hours).

☐ Expedited Review (24 hours). By checking this box, I certify application of the 72-hour standard review timeframe could seriously jeopardize the member's health or life, or their ability to regain maximum function.

I. MEMBER INFORMATION		**II. PRESCRIBER INFORMATION**	
Name:		Name:	
ID Number:		Specialty:	
Date of Birth:		NPI/DEA Number:	
Address:		Facility Name & Address:	
Phone Number:		Office Contact Name:	
Weight:		Phone Number:	
Height:		Fax Number:	

III. MEDICATION REQUESTED		**IV. DRUG DISPENSING AND ADMINISTRATION**
Drug Name:		Where drug will be administered: ☐ Physician's office ☐ Outpatient hospital: Name: _____ ☐ Inpatient hospital: Name: _____ ☐ *Home ☐ Other: _____
Directions/SIG (**dose, route,** and **frequency**):	Dose: Route: Frequency:	If drug is **administered in healthcare professional setting**: Will the provider be buying and billing, or will drug be procured from specialty pharmacy*? ☐ Buy and bill ☐ Specialty pharmacy* (*only participating pharmacy is CVS/Caremark; otherwise obtain via Part D benefit)
HCPCS/J-Code & modifier:		
Start date of therapy:		
If continuing therapy, include Florida Blue prior approval	Prior Florida Blue approval Cert #:	Note: If member is picking up drug at a pharmacy, must submit request for Part D coverage.

V. ADDITIONAL CLINICAL INFORMATION	
ICD-10 Code:	
Diagnosis:	

Is the medication being requested for use in an ongoing investigational trial? ☐ YES ☐ NO

VI. MEDICATION HISTORY (for this diagnosis)

List therapeutic alternatives previously and currently used with start/end dates and outcomes:

	Drug Name, Strength, and Dosage	Dates of Therapy (start/end dates)	Reason for Discontinuation
1			
2			
3			

Note: Step therapy is required, and the definition of medical necessity must be met, for certain higher-cost non-preferred medications: https://www.floridablue.com/providers/medical-pharmacy-info/part-b-step-therapy

PRESCRIBER NAME	**SIGNATURE**	**DATE & TIME**

VII. PERTINENT CLINICAL INFORMATION

Clinical information is required for a determination. Missing information and lack of prompt response to requests for additional information may delay response time. **Please attach** pertinent medical history, progress notes, laboratory, and diagnostic test results, which may support approval. Any additional notes can be included on the next page.

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Notes: