



Provider-Administered Medication Authorization

Date: ___/___/_____

Fax this completed form along with clinical information to Pharmacy Management at **1-888-343-4232**.

For a faster response time, you can also submit coverage review requests digitally through **Availity.com**.

Request for Expedited Review

By placing a check mark here, I certify the standard review time may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Member Name: _____

Member Date of Birth: ___/___/_____ BlueCross BlueShield of Tennessee Member ID #: _____

Case Information

Contact Name: _____

Phone: _____ Fax: _____ Requested date for authorization start: ___/___/_____

Diagnosis with Diagnosis Code(s): _____

Continuation of Care: Yes No

For the most current drug list requiring prior authorization, visit the Provider-Administered Specialty Pharmacy at <https://www.bcbst.com/docs/pharmacy/provider-administered-specialty-pharmacy-list.pdf>

Important Note: Please provide the information in the grid below. Without this information your request will be returned and may delay the review.

Drug Name & Strength	CPT Codes	Dosage/Units	Frequency	# of Doses

Please attach pertinent Clinical Information

Place of Service

Ambulatory/Outpatient MD Office Inpatient

Requesting Provider Information

Physician Name: _____

Physician Address: _____

Physician Number: _____ Tax ID: _____ NPI: _____

Physician Phone: _____ Fax: _____

Rendering Provider Information

Physician Name: _____

Physician Address: _____

Physician Number: _____ Tax ID: _____ NPI: _____

Physician Phone: _____ Fax: _____

Facility Name (if in a facility): _____

Facility Address: _____

Facility Number: _____ Tax ID: _____ NPI: _____

Facility Phone: _____ Fax: _____