blue of california

September 19, 2014

Subject: **New state mandated standardized pharmacy prior authorization form required beginning October 1, 2014**

Dear Valued Network Provider,

Effective October 1, 2014, California Senate Bill 866 (codified at Health and Safety Code Section 1367.241 and Insurance Code Section 10123.191) requires all faxed prior authorization requests for drugs covered in the outpatient prescription benefits for non-Medicare plan enrollees with a fully insured health plan to be submitted on California's new standard *Prescription Drug Prior Authorization Request Form (CA PA Request Form).** A copy of the *CA PA Request Form* is enclosed.

Please begin using the CA PA Request Form for your prescription drug prior authorization requests on October 1, 2014 for all of your Blue Shield of California non-Medicare plan patients. We will also make this form available to you online. To download the new "fillable" form, visit blueshieldca.com/provider > guidelines & resources > forms > prior authorization forms.

The process for requesting prior authorization from Blue Shield for drug admininistration has not changed and our Pharmacy Services team is available to assist you by phone at **(800) 535-9841**and by fax at **(888) 697-8122,** Monday and Wednesday through Friday from 8:30 a.m. to 5 p.m. and Tuesdays from 8:30 a.m. to 4 p.m.

Thank you, in advance for your compliance with this new state mandated requirement.

Sincerely,

Nancy E. Stalker, PharmD
Vice President, Pharmacy Services

Enclosure: *Prescription Drug Prior Authorization Request Form*

**The California Department of Insurance (CDI) requires the new form to be used beginning October 1, 2014 for patients covered under CDI regulated health insurance plans. The Department of Managed Healthcare (DMHC) will require use of the form beginning January 1,2015 for patients enroilled in DMHC regulated health plans. Blue Shield requests that you begin submitting requests on the CA PA Request Form for all non-Medicare plan patients beginning October 1, 2014.*

T9790 (8/14)

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: Blue Shield of California

Plan/Medical Group Phone#: (800) 535-9481

Plan/Medical Group Fax#: (888) 697-8122

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg):_____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal

If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?

☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____

☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:

☐ Patient's Home ☐ Long Term Care

☐ Physician's Office ☐ Home Care Agency ☐ Other (explain):_____

☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care _____

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-9/ICD-10:**

3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date**:_____

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Plan Use Only: Date of Decision:_____

☐ Approved ☐ Denied Comments/Information Requested: _____

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