Blue Cross and Blue Shield of Texas

Topical Verapamil Override Request Form

Clinical Pharmacy Programs: phone 972-766-2725 or fax 800-986-9980

Please fill out the form completely. Incomplete forms may be returned for additional information.

- Date of request: _____________________

- **Blue Cross and Blue Shield of Texas (BCBSTX) member information:**

Patient first name: ______________________ Patient last name: ___________________________

Patient address: ____

City _____________________________ State ___________________ Zip ____________________

Patient BCBSTX ID number ______________________________Patient date of birth _____________

- **Physician/ Provider information:**

First name: _______________________ Last name: __________________________________

Medical license # or DEA number ____

Telephone number: _______________________ Fax number: ______________________________

Address ____

City _______________________ State __________ Zip ____________________________

Physician signature ____

- **Requested medication:**

Drug Name and Strength: ____

Patient Diagnosis: ____

Quantity requested: ____