

Blue Cross and Blue Shield of Texas  
**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: _____

PRESCRIBING PHYSICIAN / PROVIDER INFORMATION	
First Name: _____	Last Name: _____
Medical License # or DEA number: _____	
Telephone Number: _____	Fax Number: _____
Address: _____	
City: _____	State: _____ ZIP: _____
Prescribing Physician Signature: _____	

REQUESTED MEDICATION INFORMATION	
Drug Name: _____	Drug Strength: _____
Quantity requested per month and therapy duration: _____	
Route of Administration: _____	
ICD-9: _____	
Previous Drug Therapies tried and outcome: _____	
<b>Note: To aid in expediting this request, please include (1) detailed letter of medical necessity; and (2) copy of patient medical records, including information on all therapies utilized to treat the specific diagnosis for which additional medication is being requested.</b>	

BCBSTX COMMENTS (to be completed only by BCBSTX Pharmacy Staff)
_____
_____



**BlueCross BlueShield  
of Texas**

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