

**BRAND SELECTIVE SEROTONIN
REUPTAKE INHIBITOR (SSRI)
PREAUTHORIZATION REQUEST
PHYSICIAN FAX FORM**



**BlueCross BlueShield
of Texas**

ONLY the prescribing physician may complete and fax this form.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcbstx.com

Patient first name _____ Patient last name _____

Blue Cross ID number _____ Date of birth (MM/DD/YYYY) _____

Patient address _____ Patient Phone (_____) _____

Requesting physician _____

Physician specialty _____ Physician UPIN# _____

Physician signature _____ Date _____

Physician (clinic name) and address _____

Phone (_____) _____ Fax (_____) _____

MEDICATION REQUESTED _____

1. Patient's diagnosis to be treated with requested medication _____

2. Is the patient currently treated with the requested medication? Yes No

If yes, when was treatment with the requested medication started? _____

3. Does the patient have a history of past use of any generic selective serotonin reuptake inhibitor (SSRI)? Yes No

If no, please list reason(s) _____

4. Please list all other medications the patient is **currently taking** for treatment of this diagnosis. _____

5. Please list all medications the patient has **previously tried and failed** for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) _____

6. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____

PLEASE FAX OR MAIL THIS FORM TO:
Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC, Clinical Review Department
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE: _____
Fax: 877.480.8130 **Phone:** 800.289.1525

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