CABLIVI
QUANTITY LIMIT REQUEST
PRESCRIBER FAX FORM

ONLY the provider may complete this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/pharmacy/rx-prior-auth

PATIENT AND INSURANCE INFORMATION **Today's Date:**_____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description**:**

Medication Requested: Strength:

***Your request will be reviewed for the generic equivalent unless you specify brand is required.**

Dosing Schedule: Quantity per Month:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
   If yes, when was treatment with the requested agent started? _____
2. Is the request for a new (different) episode of acquired thrombotic thrombocytopenic purpura (aTTP) requiring the initiation (reinitiation) of plasma exchange for the treatment of aTTP? ☐ Yes ☐ No
3. Has the patient had at least one recurrence (reinitiation of plasma exchange) of aTTP while using the requested agent during the current course of therapy? ☐ Yes ☐ No
4. Has the patient had more than 2 recurrences of aTTP while using the requested agent during the current course of therapy? ☐ Yes ☐ No
5. Please list all reasons for selecting the **requested medication** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions). _____
   _____
6. Please list all other medications the patient is **currently taking** for treatment of this diagnosis. _____
   _____
   _____
7. Please list any other 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.)

_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Please fax or mail this form to:
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TOLL FREE

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