ANTI-INFLUENZA AGENTS
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 preauthorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/pharmacy/star-kids-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:

Dosing Schedule: Quantity per Month:

1. Is the patient currently treated with the requested dose of the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested dose started?_____
2. Does the patient require additional courses of therapy due to additional episodes of acute influenza infection? ☐ Yes ☐ No
3. Does the patient require additional courses or increased duration of therapy for prophylaxis after exposure to an influenza-infected person? ☐ Yes ☐ No
4. Is the requested medication in supply shortage? ☐ Yes ☐ No
5. Please list all reasons for selecting the requested **medication, quantity and dosing schedule** (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried). _____
6. 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.)

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

7. Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. (Please include strength and quantity per month.)

_____	Quantity: _____	_____	Quantity:_____
_____	Quantity: _____	_____	Quantity:_____
_____	Quantity: _____	_____	Quantity:_____

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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