



An Independent Licensee of the Blue Cross and Blue Shield Association

**PRESCRIPTION DRUG  
MEDICATION REQUEST FORM  
FAX TO 1-412-544-7546**

Please use separate form for each drug. Print, type or WRITE LEGIBLY and complete the form in full.  
See reverse side for additional details

PATIENT INFORMATION			
Subscriber ID Number		Group Number	
Patient Name			Date of Birth
Patient Address		City	State      Zip Code
CLINICAL / MEDICATION INFORMATION			
Drug Name		Strength or Dose	Requested Quantity per Month
Diagnosis			
Alternatives Tried / Used By Patient (if applicable)			
Drug Name	Strength	Documentation of Failure of Therapy	
Drug Name	Strength	Documentation of Failure of Therapy	
Drug Name	Strength	Documentation of Failure of Therapy	
Medical Rationale / Reason for Drug Therapy / Treatment Plan			
PHYSICIAN INFORMATION (needed for mailing notification - please print legibly)			
Physician Name		Phone	Fax
Physician Address		City	State      Zip Code
Suite / Building		Physician Signature	Date
FOR INTERNAL REVIEW			
<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Not Applicable <input type="checkbox"/> Benefit Denial			
Reason Code	Received Date	Decision Date	Reviewer

Once a clinical decision has been made, a decision letter will be mailed to the patient and physician.

For other helpful information, please visit the Highmark Web site at:

[www.highmark.com](http://www.highmark.com)

To view the formulary on-line, please visit our Web site at <http://highmark.formularies.com>

## Instructions for Completing the Form

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.  
*NOTE: The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form to **1-412-544-7546**

Or mail the form to: **Medical & Pharmacy Affairs**  
**P.O. Box 279; Pittsburgh, PA 15230**

### Clinical Management Procedures

In general, when requesting coverage for a medication, the following information in the bullet points below is required:

#### Non-Formulary

- Most products: documentation of a trial of at least two formulary products
- Beta-blockers, calcium channel blockers, or analgesics: documentation of a trial of at least three formulary products

#### Prior Authorization

For the following drugs and/or therapeutic categories, the diagnosis, applicable lab data, and involvement of specialists are required, plus additional information as specified:

- Anti-rheumatic drugs (Enbrel, Humira, Kineret)
  - Forteo: at least two other osteoporotic therapies and risk for fractures (e.g., T-score)
  - Growth Hormone: bone age, growth chart, and stim tests
  - Smoking Cessation: treatment plan also required
  - Wellbutrin: not covered for smoking cessation therapy
- Miscellaneous Items:**
- Contraceptives, Fertility agents, Gleevec, Interferons, Iressa, Provigil, Retin-A, Tracleer

#### Managed Prescription Drug Coverage (MRxC)

For the following drugs and/or therapeutic categories, the diagnosis, **quantity requested**, and **alternatives tried** are required.

- Migraine: preventative medications, if applicable
- Onychomycosis (Lamisil and Sporanox)
- Leukotriene Modifiers (Singulair, Accolate, and Zflo)
- Pain Management: treatment plan also required
- COX-II Inhibitors and Anti-Secretory Agents (H<sub>2</sub> antagonists and proton pump inhibitors): please call our claims processor at **1-800-753-2851**.

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