FORMULARY EXCEPTION
PHYSICIAN FAX FORM

Blue Cross Community Family Health Plan

ONLY the prescriber may complete and fax 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. To download additional forms, please visit *www.bcbsilcommunityfamilyhealthplan.com*

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

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

INSURANCE INFORMATION

BCBS ID Number:	Group Number:

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician 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 medication? ..... ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Please list all reasons for selecting the requested **medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____
3. Please list all other medications the patient is **currently taking for treatment of this diagnosis.** _____
4. 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.) _____

Please fax or mail this form to:
Blue Cross and Blue Shield of Illinois
c/o Prime Therapeutics LLC, Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE
Fax: 877.243.6930 **Phone: 800.285.9426**