BlueCross BlueShield of Tennessee | 1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbst.com

Provider-Administered Medication Authorization

Date: ____/____/_____

Fax this completed form along with clinical information to Pharmacy Management at **1-423-591-9514**.
For a faster response time, you can also submit coverage review requests digitally through **Availity.com**.

Request for Expedited Review

☐ By placing a check mark here, I certify the standard review time may seriously jeopardize the life or health of the member or the member's ability to regain maximum function (Not applicable for BlueCare members).

Member Name: _____

Member Date of Birth: ____/____/_____ BlueCross BlueShield of Tennessee Member ID #:_____

Member Height: _____ Member Weight: _____

Case Information

Contact Name: _____

Phone: _____ Fax: _____ Requested date for authorization start: ____/_____/_____

Diagnosis with Diagnosis Code(s): _____

Continuation of Care: ☐ Yes ☐ No

For the most current drug list requiring prior authorization, visit the Provider-Administered Specialty Pharmacy at **https://www.bcbst.com/docs/pharmacy/provider-administered-specialty-pharmacy-list.pdf**

Important Note: Please provide the information in the grid below. Without this information your request will be returned and may delay the review.

Drug Name & Strength	CPT Codes	Dosage/Units	Frequency	# of Doses

Please attach pertinent Clinical Information

Place of Service

☐ Ambulatory/Outpatient ☐ MD Office ☐ Inpatient

Requesting Provider Information

Physician Name:_____

Physician Address: _____

Physician Number: _____ Tax ID: _____ NPI: _____

Physician Phone: _____ Fax:_____

Rendering Provider Information

Physician Name:_____

Physician Address: _____

Physician Number: _____ Tax ID: _____ NPI: _____

Physician Phone: _____ Fax:_____

Facility Name (if in a facility): _____

Facility Address:_____

Facility Number:_____ Tax ID: _____ NPI: _____

Facility Phone:_____ Fax:_____

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