



- **Submit the completed form:**
  - By fax, to: Attention Pharmacy at 1-855-811-9326
  - By mail, to: PerformRx,  
Attention: 4<sup>th</sup> Floor Prior Auth Dept  
200 Stevens Drive  
Philadelphia, PA 19113

**Note: Blue Cross Complete's prior authorization criteria for a brand-name (DAW) request:** Documentation of an adverse event or lack of efficacy with the generic formulation **and** completion of an **FDA MedWatch** form. Please forward a copy of the submitted **MedWatch** form with this request. Forward the original **MedWatch** form to the FDA.

- **Submit appeal requests** directly to Blue Cross Complete by faxing to: 1-866-900-4482

**Member information**

Name:	DOB:	ID number:
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**Prescriber information**

Name:	Specialty:		
Phone:	Fax:	NPI:	
Street address:	City:	State:	ZIP:

**Medication information**

Name:	Strength requested:
Is this brand medically necessary?    No    Yes <i>If yes, provide the rationale by completing the questions below.</i>	
Quantity requested and directions:	
Anticipated length of therapy: _____ days                      3 months                      6 months                      12 months	
For diagnosis:	
Specialty/injectable medications: Medication to be delivered to physician's office (pharmacy billing) OR Office reimbursement request (physician billing)	A complete list of specialty medications is available at <b>MiBlueCrossComplete.com</b> > Pharmacy > <b>Specialty Drug Guide</b> .
Preferred medications tried, previous therapy:	<i>Note: Please include strength, frequency and duration.</i>
Rationale and any additional information relevant to the review of this request:	

<b>Prescriber signature:</b>	<b>Date:</b>
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