

Contraceptives (Oral, Transdermal, Intravaginal Ring)



An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Request (Physician to Complete)

Facsimile Transmittal Sheet

Date: ___/___/___

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____

Prescriber's Fax Number: _____

Prescriber's Office Address: _____
Street Suite # City State Zip

Patient Name: _____

Patient ID: _____ Patient DOB: ___/___/___

Thank you for taking the time to provide clinical information to ensure appropriate drug therapy for your patient. Please answer the following questions and fax this form back to (866) 884-4345.

1. Please provide the diagnosis this therapy has been prescribed for: _____

ICD-9 Code: _____

2. Name of medication: _____

3. Directions: _____

4. Quantity/30 days: _____ units

Notes:

- An indication of contraception is not approvable.
- Only Ortho Tri-Cyclen (Tri-Sprintec, Trinessa, Tri-Previfem) or Estrostep FE will be approved for a diagnosis of acne.
- Depo-provera is not a covered prescription benefit.
- When a generic is available, the generic is a lowest copay benefit.
- Refer to the Wellmark Drug List on www.wellmark.com for current medication tier levels.

Printed Name _____

Signature _____

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient, you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy this original fax message.