



Phone: 800-842-2015 Fax: 877-837-5922

PATIENT DATA	Last Name	First Name	Policy Number	Date of Birth	Age
REQUESTING PHYSICIAN DATA	Last Name	First Name	Contact Name	Fax Number ()	
BCBSLA Provider Number	Area of Practice/Specialty	Name of Place of Treatment	Treatment Center Provider #	Phone Number ()	
BILLING DATA	Diagnosis Code(s) (ICD-9): 1) 2)		CPT-4/HCPCS Code	Other Codes	

DRUG INFORMATION - Byetta/Symlin/Victoza

<input type="checkbox"/> BYETTA®	<input type="checkbox"/> SYMLIN®	<input type="checkbox"/> VICTOZA®
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INDICATION / DIAGNOSIS

<input type="checkbox"/> Type 1 diabetes mellitus	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Type 2 diabetes mellitus	<input type="checkbox"/> Other: _____

DRUG INFORMATION - Lidoderm/Quenza

<input type="checkbox"/> LIDODERM®	<input type="checkbox"/> QUTENZA®
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INDICATION / DIAGNOSIS

<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Pain associated with rib fractures
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Post herpetic neuralgia
<input type="checkbox"/> Musculoskeletal Pain/Myofascial Pain	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Neuropathic pain	<input type="checkbox"/> Other: _____

OTHER CLINICAL INFORMATION (Check ALL that apply)

<input type="checkbox"/> Yes <input type="checkbox"/> No Will the requested drug be used in combination with a standard myofascial trigger point (MTP) treatment modality?	<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient tried at least 3 other pharmacologic therapies for their osteoarthritis? If so, specify: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient tried 3 other pharmacologic therapies commonly used to treat low back pain? If so, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Will the patient be receiving the drug in the physician's office? If no, list name of servicing provider: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient tried 1 other pharmacological therapy used to treat carpal tunnel syndrome? If so, specify: _____	List any other relevant clinical info if applicable: _____

DRUG INFORMATION- Ophthalmic Prostaglandins

<input type="checkbox"/> LUMIGAN®	<input type="checkbox"/> TRAVATAN Z®	<input type="checkbox"/> XALATAN®
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INDICATION / DIAGNOSIS

<input type="checkbox"/> Elevated intraocular pressure (IOP) caused by open-angle glaucoma (OAG) or ocular hypertension (OH)	<input type="checkbox"/> Cosmetic condition; specify: _____
	<input type="checkbox"/> Other: _____

PHYSICIAN SIGNATURE _____ Prescribing Physician	DATE _____
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Note: On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. We recommend you contact BCBSLA at 800-922-8866 to verify benefits. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

Incomplete forms will not be processed