CLEAR DATA

BlueCross BlueShield of Kansas

CLINICAL REVIEW
FAX FORM FOR COMPOUNDED PRESCRIPTIONS

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is required for medical necessity determination.

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:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

REQUEST INFORMATION

Patient's Diagnosis:		Patient's height: Patient's weight:
Dosing Schedule:	Treatment Start Date:	Length of Therapy:

Please provide the patient's medical records that are relevant for this request.

Submitted documentation should include the following:

- Medications the patient has previously tried and failed for this diagnosis (including dates/duration of treatment)
- Medications the patient is currently taking
- Supporting documentation for off label use or dosing (e.g. peer reviewed articles, treatment guidelines)

Please list all ingredients (attach additional pages if needed):

Product (include strength if applicable)	Quantity (include unit of measure)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PRESCRIBER SIGNATURE: _____

PLEASE NOTE: Incomplete requests will be returned for additional information.

Please fax or mail this form to:
Blue Cross and Blue Shield of Kansas
ATTN: PRE-DET
1133 SW Topeka Blvd.
Topeka, KS 66629-0001
Please Fax to: 785.290.0711
Toll Free Phone: 800.432.3990

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