

**ANABOLIC STEROID
PREAUTHORIZATION REQUEST
PHYSICIAN FAX FORM**



**BlueCross BlueShield
of Texas**

ONLY the prescribing physician may complete and fax this form.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcbstx.com

Patient first name _____ Patient last name _____

Blue Cross ID number _____ Date of birth (MM/DD/YYYY) _____

Patient address _____ Patient Phone(_____) _____

Requesting physician _____

Physician specialty _____ Physician UPIN# _____ Physician NPI# _____

Physician signature _____ Date _____

Physician (clinic name) and address _____

Phone (_____) _____ Fax (_____) _____

MEDICATION REQUESTED _____

1. Patient's diagnosis to be treated with requested medication _____

2. If the patient's diagnosis is anemia, what is the patient's hematocrit? _____

3. Has the patient had significant weight loss following surgery, infection or trauma? Yes No

If yes, what has the percent weight loss been over the past 6 months? _____%

Please indicate the patient's height _____ weight _____ and BMI _____

Has the patient been evaluated to rule out treatable causes of weight loss? Yes No

4. Does the patient require long-term treatment with corticosteroids? Yes No

5. Please list all other medications the patient is currently taking _____

6. Does the patient's medical history include any of the following? Liver disease Yes No

Hyperlipidemia Yes No

Renal disease Yes No

Coronary artery disease (CAD) or
atherosclerosis Yes No

PLEASE FAX OR MAIL THIS FORM TO:

Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC, Clinical Review Department
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE:

Fax: 877.480.8130 Phone: 800.289.1525

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