



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

GENERAL PRESCRIPTION DRUG COVERAGE AUTHORIZATION REQUEST FORM

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

GENERAL INFORMATION		Patient Name	
Request Type (please check one)		Channing Lawson	
☒ Prior Authorization		Patient's Home Address	
☐ Step Therapy Exception		4724 SOUTH CT ST APT 107	
☐ Request for Quantity Limit Exception		City	State
☐ Appeal		MONTGOMERY	AL
☐ Mandatory Generic Exception		Zip	36105
☐ Request for Non-Formulary Exception		Date of Birth (mm/dd/yyyy)	Contract Number (include prefix)
		0 4 / 1 9 / 1 9 9 1	Q A U 8 1 5 4 7 6 3 5 9

PRESCRIBER INFORMATION		
Prescriber Name		Practice Type
Lindsey Barton		☐ PCP
Practice Address		☐ Specialty: _____
7461 East Drive		National Provider Identifier (NPI)
City	State	1 2 1 5 2 8 5 8 7 9
Montgomery	AL	
Office Phone	Office Fax	
(334) 361-7306	(334) 361-8966	

REQUEST TYPE
(Please check one) ☐ Initial Authorization ☐ Authorization Renewal (Please attach any additional medical information.)

TREATMENT INFORMATION		
Drug/Strength/Frequency/Quantity Requested: Vraylar 3MG Capsules		Duration of Disease (Years):
1 tablet daily 30 per 30 days		over 5 years
Place of Services:	Route of Administration:	Healthcare Professional to Administer:
Auburn University of Montgomery	Oral	☐ Yes ☒ No
ICD-10 Codes: (F31.9) Bipolar disorder, unspecified		

Medical rationale for use (include chart notes if possible):

Patient has been on this medication for over 5 years

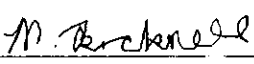
List medications this patient has tried for this condition (include current medications and titration history if applicable)

Drug	Strength/Frequency	Dates of Therapy	Outcome of Therapy
1.			
2.			
3.			
4.			
5.			

Does this patient have any co-morbid conditions that will affect therapy: ☒ Yes ☐ No

If so, please list: Hypertension

Note: Medications received through manufacturer coupons or samples are not accepted as justification of prior therapy.

Prescriber Signature	
(Required for processing request)	
I certify this information is complete and correct to the best of my knowledge.	 Prescriber Signature
	Date 02/22/2022

Please attach any additional medical justification.

SUBMISSION INSTRUCTIONS

FAX

You may fax the signed and completed form to
Pharmacy Review at:
1-866-606-6021

MAIL

You may mail the signed and completed form to:
Pharmacy Review
Post Office Box 3210 • Auburn, AL 36831

Patient: Channing Lawson DOB: 04/19/1991
Member: QAU815476359
Sent: 02/22/2022

Notes**[1] Explanation**

The patient is a new patient to our office. He recently moved from Iowa where he was under the care of Jenna Berendzen, CRNP at Covenant Family Solutions in Cedar Falls, Iowa where he has been prescribed this medication for over 5 years. Patient previously had no issue with having medication filled, but since moving to Alabama and changing insurances, he is now required to obtain a prior authorization. This patient is unable to provide details as to what other medications he has previously tried due to his previous provider retiring since he left Iowa.

REQUEST FOR PRIOR AUTHORIZATION
ADAMS DRUGS (TAYLOR ROAD)
7200 COPPERFIELD DR
MONTGOMERY, AL 36117-7100
P: (334) 386-9370 F: (334) 386-9371
NPI: 1033423199



Patient: CHANNING LAWSON
4724 SOUTH CT ST APT 107
MONTGOMERY, AL 36105

DOB 04/19/1991
Gender M
Phone (217) 493-1382

Rx: 577298
Prescriber LINDSEY BARTON
Prescriber Phone (334) 361-7306
Prescriber Fax (334) 361-8966
Medication VRAYLAR 3 MG CAPSULE
Qty Prescribed 90 Refills Authorized 1
Dispensed 0 time(s) for a total qty of 0
Date Written 1/18/2022 Fill Attempted 2/21/2022

Directions
TAKE 1 CAPSULE BY MOUTH ONCE DAILY

Insurance: BC/BS ALABAMA BIN 004915 PCN
Help Desk (800) 216-9920 Card Id QAU815476359
Prior Auth Group 37655
STEP THERAPY AND QUANTITY LIMITS APPLY-- Relation
PA REQUIRED.

Reason for Service Code	Free Text Message	Clinical Significance	Previous Date of Fill	Previous Quantity
----------------------------	-------------------	--------------------------	--------------------------	----------------------

Please contact the insurance company for a prior authorization on behalf of the patient and return this fax to (334) 386-9371.

Comments:

PA Number _____ ☐ PA Number not required

--- OR ---

Change Drug _____ # _____ Sig _____

Authorized _____

The documents accompanying this telecopy transmission contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity referred above. The authorized recipient of the information is prohibited from disclosing the information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by state law.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reference on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to return of these documents.