SUBMIT or Print this form by using buttons at the bottom of the page.

General Help Instructions

Pharmacy Prior Authorization Request Form

*Required Fields

RegenceRx™ PHARMACY BENEFIT MANAGEMENT

Plan Information

*Select Plan:
- ☐ Regence Life & Health
- ☐ Regence BlueShield of Idaho
- ☐ Regence BlueCross BlueShield of Oregon
- ☐ RegenceRx
- ☐ Asuris Northwest Health
- ☐ Regence BlueShield (Washington)
- ☐ Regence BlueCross BlueShield of Utah

Fax completed form to: 1 (888) 437-1510

Questions or Assistance: 1 (888) 437-1508

Patient Information

*Last Name: _____ *First Name: _____ M.I.: _____

*Patient I.D.: _____ *Date of Birth: _____ *Patient Sex: _____

Jump to: www.RegenceRx.com | Medication Policies

Click here to View Criteria for the Selected Medication

Medication Information

*Medication to Prior Authorize:

Drugs A - L _____

Drugs M - Z _____

Select Medication from Drop-Down List Above or Type in Medication Name on Line Provided

One drug per PA form. Click below to show selected drug PA requirements

Strength: _____ Quantity per Month: _____ Length of Therapy: _____ Currently Taking? _____

Directions: _____

Please list which medications the patient has tried for this diagnosis (include chart notes if possible):

Medication Name	Dosage	Date(s) Medication Was Used	Outcome

Patient Diagnosis: _____

Medical Rationale: _____

Provider Information

Provider Name - *Last: _____ *First: _____ Degree: _____

Street Address: _____

City, St, Zip: _____

*Phone Number: _____ *Fax Number: _____ Contact: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Provider Signature: _____ Date: _____

© 2005 - 2012 RegenceRx. All rights reserved.

Administered by: Pharmacy Services. rev PA.67 04/03/2012

Clear Form | Print Blank Form | *Print Filled in Form* | *Submit Online*