



**WyoBLUE
ADVANTAGE**

**Medicare Advantage Part B Drug Request Form
Clinical Review Request for WyoBlue Advantage PPO
Medicare Advantage Health Plan Members**

Attention: – Pharmacy Department
Fax: 1-877-369-3365

Date: _____

Instructions: This form may be used by participating providers to request clinical review of drugs covered under the medical benefit for WyoBlue Advantage PPO Medicare Advantage Health Plan. Complete this form and fax it to 1-877-369-3365 along with supporting clinical documentation. Please contact the pharmacy team at 1-844-965-5080 with any questions.

**ALL REQUESTED INFORMATION MUST BE PROVIDED FOR CONSIDERATION FOR COVERAGE.
PLEASE TYPE OR PRINT CLEARLY**

Step 1: Patient and Physician Information	Patient Information		
	Name:		
	DOB:		
	Member ID:		
	Ordering Provider Information		
	Name:		
	Specialty:		
	NPI:		
	Contact Name & Phone #		
	Fax:		
Administering Provider/Facility Information			
Name:			
Specialty:			
NPI:			
Phone:			
Fax:			
Step 2: Provider of Service and Treatment Information	**Required for ALL requests** Drug Information		
	Treatment Start Date:	Length of treatment:	
	Diagnosis Code(s): _____ HCPCS: _____		
	Drug Name: _____	Dose: _____	Frequency: _____
	Place of Service (Please Check): <input type="checkbox"/> Home <input type="checkbox"/> Outpatient <input type="checkbox"/> Provider Office		
	Please fax all required clinical documentation to 1-877-369-3365		
	Request for Expedited Review. I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.		

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