



**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):      Home      Outpatient      Provider Office

**Step 3:** Other  
Relevant History  
and Information

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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