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.