blue CALIFORNIA
PROMISE

| **Treatment Authorization Request** | **Gene Expression Profiling, Protein Biomarkers, and Multimodal Artificial Intelligence for Prostate Cancer Management** |
|---|---|
| **Standard Fax Number:** (323) 889-6506 | **Urgent Fax Number:** (323) 889-5403 |

**Use AuthAccel - Blue Shield's online authorization system** - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

**Notice: Blue Shield of CA has a 5 Business Day turn-around time on all Standard Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.**

☐ **New Standard Request** ☐ **New Urgent Request** ☐ **Retro Request** ☐ **Standing Referral**

**Important For Urgent Requests**: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. ***If there is no MD signature present, the request will be processed as a Standard request.***

**MD Signature REQUIRED For Urgent Requests Only**:

☐ **Modification Or** ☐ **Extension Requests Complete the Section Below:**

| Date Last Authorized: | Previous Authorization Number: |
|---|---|
| MD/NP/PA justification for modification or extension: | |

**Patient Information:**

| First Name: | Last Name: |
|---|---|
| Date of Birth: | Blue Shield of California Promise ID Number: |
| Street Address: | |

| City: | State: | Zip Code: |
|---|---|---|

**Referring/Prescribing Provider:**

| Name: | Tax ID: | NPI: |
|---|---|---|
| Street Address + Suite#: | | |

| City: | State: | Zip Code: |
|---|---|---|

| Phone: | Fax: |
|---|---|
| Type of Provider:<br>☐ PCP ☐ Specialist | Specialist Type (if applicable): |
| Contact Name and Phone Number: | |

**Servicing/Billing: Provider/Vendor/Lab** ***If same as Referring/Prescribing Provider, Check Here*** ☐

| Name: | Tax ID: | NPI: |
|---|---|---|
| Street Address + Suite#: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | |
| Specialist Type: | | |
| Contact Name and Phone Number: | | |

| **If Servicing Provider is billing as part of a Group Contract, enter the Group information below:** | | |
|---|---|---|
| Group Name: | Tax ID: | NPI: |
| Street Address + Suite#: | | |
| City: | State: | Zip Code: |

| **Billing Facility (If Applicable):** | | |
|---|---|---|
| Facility Name | Tax ID: | NPI: |
| Street Address + Suite#: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | |
| Contact Name and Phone Number: | | |

| **Anticipated Date of Service:** | **If Lab, Draw Date:** |
|---|---|

**Place of Service: (Check one box only):**

| | | | | | |
|---|---|---|---|---|---|
| | Office | | Group Home | | On-campus Outpatient Hospital |
| | Acute Rehab | | Home | | Skilled Nursing Facility |
| | Ambulance – Air or Water | | Hospice | | Telehealth |
| | Ambulance – Land | | Independent clinic | | Urgent Care Facility |
| | Ambulatory Surgical Center | | Independent laboratory | Other - Please specify: | |
| | Assisted Living Facility | | Inpatient hospital | | |
| | Birthing Center | | Intermediate Care Facility | | |
| | Custodial Care Facility | | Nursing Facility | | |
| | End stage Renal Disease Tx | | Off-campus Outpatient Hospital | | |

**Please enter below all codes requested; unlisted codes must have a description.**
**Include the quantity for each code requested and if applicable, left, right or bilateral designations.**

ICD-10 Codes(s):

CPT/HCPC Code(s):

**For questions: Call Blue Shield Promise Provider Services at (800) 468-9935**

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**Please include the documentation listed below when you return this form to Blue Shield of California Promise Health Plan:**

- ☐ History and physical and/or consultation notes, including:
  - ☐ Clinical stage (TNM)
  - ☐ NCCN risk category
  - ☐ Biopsy Gleason score
  - ☐ PSA level/density
  - ☐ Number of biopsy cores with presence of disease including cancer involvement
  - ☐ Pertinent comorbidities
- ☐ Test requested and reason for test
- ☐ Projected life expectancy
- ☐ Documentation that individual is a candidate for active surveillance or definitive therapy
- ☐ Prior treatment (if applicable) including prostatectomy if applicable
- ☐ Laboratory report/results