State of Maryland Prescription Drug Transition Fill Form

CareFirst
Family of health care plans

INSURANCE INFORMATION			
Subscriber's Name		Subscriber's Date of Birth	
Street Address		Subscriber Member ID #	
City		Group Name	Effective Date of Coverage
State	Zip Code	Group Number	Check one ◯ HMO ◯ POS ◯ PPO
Home Telephone ( ) –		Cellular ( ) –	

PATIENT INFORMATION	
Patient's Name	Patient's Date of Birth
Patient's Signature	Date
Employee's Signature*	Date

PHYSICIAN INFORMATION			
Name of Physician Currently Treating Condition	Diagnosis Code(s) (ICD-10)	Date Treatment Started	Chronic Condition? ◯ Yes ◯ No

Treating Physician's Specialty	Please attach one of the following: ◯ A detailed receipt showing **drug name**, date of last fill, quantity, strength, and prescriber ◯ Copies of a prior authorization approval letter from the previous carrier for the drug being requested ◯ Copy of the physician progress note or administration log listing drug, dose, and date administered for injectable drugs ◯ Copies of an Explanation of Benefits (EOB) from the previous carrier for the drug being requested
Street Address	
City	
State / Zip Code	
Telephone ( ) –	
Physician's Signature	Date

*If the patient is under the age of 18, the employee/retiree must sign this form.

How do I submit the Form?

1. You or your physician may fax the form and any attachments to:

   410-528-7902
   Attention: State of MD Drug Transition Fill Form

2. Scan and email a completed, signed form and attachments to:

   CFCommandCenter@caremark.com

3. Mail the completed form and any attachments to:

   CareFirst BlueCross BlueShield
   Department of Pharmacy
   1501 South Clinton Street
   Mail Stop: CT 05-10
   Baltimore, MD 21224