BlueCross BlueShield of North Carolina

ACA COPAY WAIVER

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]	
CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX	
PRESCRIBER ADDRESS	CITY	STATE	ZIP
PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER M F

Select medications are available with no cost sharing for members. These drugs and more information can be found at http://www.BlueCrossNC.com/preventive. If a member cannot use these medications for medical reasons, a copay waiver can be requested for another drug with this form.

This form is NOT a request for a FORMULARY EXCEPTION of a drug that is not covered on the member's formulary.

Please answer the following questions: **Diagnosis Code:** ____________

1. Is the request for brand name Soltamox (tamoxifen) oral solution?..☐ Yes ☐ No

   IF YES, please answer the following questions:

   a. Is the patient utilizing the requested medication for primary prevention of breast cancer because the patient is high risk? ………………………………………………………………..☐ Yes ☐ No
   b. Does the patient have a prior diagnosis of breast cancer?..☐ Yes ☐ No
   c. Does the patient have difficulty swallowing or cannot swallow generic tamoxifen tablets?...☐ Yes ☐ No
   d. Does the patient have a documented intolerance or hypersensitivity to generic tamoxifen tablets?…………………………………………………………………………………..☐ Yes ☐ No

2. Is the request for Femara (letrozole)?...☐ Yes ☐ No

   IF YES, please answer the following questions:

   a. Is the patient utilizing the requested medication for primary prevention of breast cancer because the patient is high risk?....………………………………………………………..☐ Yes ☐ No
   b. Does the patient have a prior diagnosis of breast cancer?..☐ Yes ☐ No
   c. Is the patient clinically able to utilize the medications available at $0 cost share (anastrozole, tamoxifen, raloxifene)? ....☐ Yes ☐ No

3. Is the request for Apretude?...☐ Yes ☐ No

   IF YES, please answer the following question:

   a. Is the patient utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV?...☐ Yes ☐ No

4. Is the request for Viread?.. ☐ Yes ☐ No

   IF YES, please answer the following questions:

   a. Is the patient utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV?...☐ Yes ☐ No
   b. Is the member clinically unable to use emtricitabine-tenofovir 200-300mg tablets (generic Truvada)?...☐ Yes ☐ No

****NOTE: continued on page 2; please sign page 3 to request copay waiver****

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5. Is the request for Descovy?..☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Is the patient utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV?..☐ Yes ☐ No
      If YES, please submit medical record documentation.
   b. Is the member clinically unable to use emtricitabine-tenofovir 200-300mg tablets (generic Truvada)?..☐ Yes ☐ No
      If YES, please submit medical record documentation.

6. Is the request for brand name Truvada?..☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Is the patient utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV?..☐ Yes ☐ No
      If YES, please submit medical record documentation.
   b. Has the patient tried the generic version of the requested medication (generic Truvada)?..☐ Yes ☐ No
      i. **If YES,** did the patient have a sub-therapeutic or intolerant response to an inactive ingredient of the generic product that is not present in the brand?................................☐ Yes ☐ No
   c. Does the patient have a documented intolerance to an inactive ingredient of the generic product that is not found in the brand?..☐ Yes ☐ No

7. Is the request for emtricitabine-tenofovir (generic Truvada)?..☐ Yes ☐ No
   IF YES, please answer the following question:
   a. Is the patient utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV?..☐ Yes ☐ No

8. Is the request for one of the following statins: atorvastatin, fluvastatin, fluvastatin ER, lovastatin ER, pitavastatin, rosuvastatin, simvastatin?..☐ Yes ☐ No
   If YES, please select the requested medication and answer the following questions:
   - ☐ Atorvastatin 10-80mg per day
   - ☐ Fluvastatin 20-80mg per day
   - ☐ Fluvastatin ER 80mg per day
   - ☐ Lovastatin ER 20-40mg per day
   - ☐ Pitavastatin 1-4mg per day
   - ☐ Rosuvastatin 5-40mg per day
   - ☐ Simvastatin 10-40mg per day

   a. Is the requested statin covered under the pharmacy benefit or has been previously approved by Blue Cross NC?..☐ Yes ☐ No
   b. Is the patient clinically unable to utilize the medications available at $0 cost share (pravastatin or lovastatin)?..☐ Yes ☐ No
   c. Is the patient 40-75 years of age?..☐ Yes ☐ No
   e. Does the patient have any of the following risk factors?
      i. Dyslipidemia..☐ Yes ☐ No
      ii. Diabetes..☐ Yes ☐ No
      iii. Hypertension..☐ Yes ☐ No
      iv. Smoking..☐ Yes ☐ No
   f. Does the patient have a calculated 10-year risk of a cardiovascular event of 10% or greater per the American College of Cardiology and American Heart Association's Atherosclerotic Cardiovascular Disease (ASCVD) calculator?..☐ Yes ☐ No

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9. Is the request for a contraceptive medication / device?..☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Please list the requested contraceptive medication / device: ___________________________________
   b. Is the requested medication/device covered under the pharmacy benefit or has it been previously approved by BlueCross NC?...☐ Yes ☐ No
   c. Is the provider requesting the non-preferred version of the prescribed contraceptive based on a determination of medical necessity?..☐ Yes ☐ No

10. Is the request for a bowel preparation medication?...☐ Yes ☐ No
    IF YES, please answer the following questions:
    a. Please list the requested bowel preparation medication: ______________________________________
    b. Is the requested medication covered under the pharmacy benefit or has it been previously approved by Blue Cross NC?...☐ Yes ☐ No
    c. Is the patient clinically unable to utilize the medications available at $0 cost share?...........☐ Yes ☐ No

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_________________________________ **Date**:__________

For Blue Cross NC members, fax form to 1-800-795-9403

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