BlueCross BlueShield of North Carolina

Non-Formulary Exception
Request Form

To submit request electronically, please go to covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: 888-446-8535

Mail: Blue Cross NC, ATTN: Part D Coverage Determination
P.O. Box 17509, Winston Salem, NC 27116-7509

Call: 888-298-7552 Blue Medicare Rx
888-296-9790 Blue Medicare HMO/PPO

Incomplete Form May Delay Processing

Prescriber Information			Patient Information
Physician Name:		NPI #:	Patient Name:
Office Contact Person:			Patient ID #:
Office Phone #:	Office Fax #:		Home Phone #:
Address:			Sex: ☐ Female ☐ Male
City:	State:	Zip:	DOB:

Diagnosis and Medication Information	
Medication Requested:	Diagnosis Code:
Strength and Route of Administration:	Dosing Schedule:
Quantity per 30 Days:	

Please answer questions below

1. Is this request for an expedited review?........ ☐ Yes ☐ No
   Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. *A standard review will have a decision made within 72 hours for a coverage determination.*

2. Please indicate if the requested medication is a: ☐ brand-name product ☐ generic product

3. Is the patient currently taking the requested medication?........ ☐ Yes ☐ No
   A. **If YES,** please answer the following questions:
      i. Please provide the treatment start date of the requested medication:___/____/________
      ii. Is the patient currently taking a *lower dose* of the requested medication (e.g., currently taking 30 mg, request is for 60 mg)?........ ☐ Yes ☐ No

4. Please list the names **AND** strengths of all medications related to this diagnosis previously tried and failed (please specify if the product was brand-name, generic, or over-the-counter) or to which the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity. Please also include any additional clinical rationale for requesting this exception. ____
   ____
   ____

5. Is the requested medication a **high-risk medication** (please refer to the patient's formulary)?........ ☐ Yes ☐ No
   A. **If YES**, please answer the following questions:
      i. Is the patient *at least* 65 years of age?........ ☐ Yes ☐ No
      ii. Do the benefits of the requested high-risk medication outweigh the risks for this patient?........ ☐ Yes ☐ No
      iii. Has the prescriber documented that the risks and potential side effects of this high-risk medication have been discussed with the patient or authorized representative of the patient?..... ☐ Yes ☐ No

I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the 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.

Physician Signature:____ Date: __________________

Blue Cross and Blue Shield of North Carolina is a HMO/PPO/PDP plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.

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