

To submit request electronically, please go to covermy meds.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: <input type="checkbox"/> Female <input type="checkbox"/> Male	
City:	State:	Zip:	DOB:
Diagnosis and Medication Information			
Drug Requested:		Diagnosis Code:	
Strength and Route of Administration:		Dosing Schedule:	
Quantity per 30 days:			
Please answer questions below			
<p>PLEASE NOTE:</p> <ul style="list-style-type: none"> * Drugs on the Specialty Tier are not eligible for a Tier Exception. * Tier Exceptions for brand name drugs will be approved to the lowest tier which contains brand name alternatives. * Tier Exceptions for biological products will be approved to the lowest tier which contains biological alternatives. * Tier Exceptions for generic drugs will be approved to the lowest tier which contains generic alternatives. * Tier Exception requests cannot be considered for drugs that do not have an alternative available on a lower tier (e.g., levothyroxine tablets). * Tier Exception requests cannot be considered for drugs that have been approved as a Formulary Exception. * See Evidence of Coverage (EOC) for more information. 			
<p>1. Is this request for an expedited review?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <i>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.</i></p> <p>2. Please indicate if the requested medication is a: <input type="checkbox"/> brand-name product <input type="checkbox"/> generic product</p> <p>3. Is the patient currently taking the requested medication?..... <input type="checkbox"/> Yes <input type="checkbox"/> No A. If YES, please answer the following: i. Please provide the treatment start date of the requested medication: ___/___/___ ii. Is the patient currently taking a <i>lower dose</i> of the requested medication (e.g., currently taking 30 mg, request is for 60 mg)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Please list the names and strengths of all medications 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 to related to this diagnosis. (Please include any additional clinical rationale for requesting this exception). _____ _____</p>			
PLEASE CONTINUE TO NEXT PAGE			

5. Is the requested agent a **high-risk medication** (please refer to the patient's formulary)?..... Yes No
- A. **If YES**, please answer the following:
- 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 potential side effects and risks 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: _____