

To submit request electronically, please go to [covermy meds.com](http://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>1. Is this request for an expedited review?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>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.</b></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  <b>A. If YES, please answer the following questions:</b>            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 <b>AND</b> 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. _____  _____  _____</p>			
<p>5. Is the requested agent a <b>high-risk medication</b> (please refer to the patient's formulary)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>A. If YES, please answer the following questions:</b>            i. Is the patient <i>at least</i> 65 years of age?..... <input type="checkbox"/> Yes <input type="checkbox"/> No            ii. Do the benefits of the requested high-risk medication outweigh the risks for this patient?..... <input type="checkbox"/> Yes <input type="checkbox"/> 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?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>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.</p>			
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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Updated: 01/01/2022