

To submit request electronically, please go to [covermymeds.com](http://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: <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:			
Please answer questions below			
Certain drugs may be covered under Medicare Part B or Medicare Part D and therefore, require prior review to determine the entity responsible for coverage (see CMS Coverage database <a href="https://www.cms.gov/medicare-coverage-database/">https://www.cms.gov/medicare-coverage-database/</a> or DME-MAC Jurisdiction C <a href="http://www.cgsmedicare.com/jc/coverage/lcdinfo.html">http://www.cgsmedicare.com/jc/coverage/lcdinfo.html</a> for Part B drug coverage clarification).			
1. Is this request for an expedited review?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b><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></b>			
2. Please indicate if the requested medication is a: <input type="checkbox"/> brand-name product <input type="checkbox"/> generic product			
3. Please identify where the requested medication will be administered to the patient: <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Outpatient facility <input type="checkbox"/> Office setting <input type="checkbox"/> Home <input type="checkbox"/> Pharmacy <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Hospice <input type="checkbox"/> Long Term Care <input type="checkbox"/> Other (specify): _____ A. If place of service is outpatient or office, will the requested medication be billed by that location?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Is the requested medication an oral anti-emetic being prescribed for nausea and/or vomiting related to any of the following conditions? A. Chemotherapy-induced nausea/vomiting..... <input type="checkbox"/> Yes <input type="checkbox"/> No i. <b>If YES, please answer question 5 on next page.</b> B. Post-operative nausea/vomiting..... <input type="checkbox"/> Yes <input type="checkbox"/> No C. Medication-induced nausea/vomiting..... <input type="checkbox"/> Yes <input type="checkbox"/> No D. Radiation-induced nausea/vomiting..... <input type="checkbox"/> Yes <input type="checkbox"/> No E. Other..... <input type="checkbox"/> Yes <input type="checkbox"/> No i. <b>If YES, please specify condition:</b> _____			
<b>PLEASE CONTINUE TO NEXT PAGE</b>			

5. For oral anti-emetics prescribed for chemotherapy-induced nausea/vomiting, please answer the following questions:
- A. Is the patient receiving **oral chemotherapy**?.....  Yes  No
- i. **If YES**, please answer the following questions:
- a. List the names of all oral chemotherapeutic agents the patient will receive: \_\_\_\_\_
- b. Is it likely that the anti-cancer drug will cause vomiting if the requested oral anti-emetic is not given?.....  Yes  No
- c. Will the patient receive the oral anti-emetic within 2 hours before the oral anti-cancer drug is given?.....  Yes  No
1. **If YES**, will the patient take the oral anti-emetic after the oral anti-cancer drug is given?.....  Yes  No
- B. Is the patient receiving **IV chemotherapy**?.....  Yes  No
- i. **If YES**, please answer the following questions:
- a. Will the patient receive the oral anti-emetic within 2 hours of chemotherapy administration?.....  Yes  No
1. **If YES**, will the patient take the oral anti-emetic beyond 48 hours of receiving chemotherapy?.....  Yes  No
- b. Will the oral anti-emetic be used as a full therapeutic replacement for IV anti-emetic drugs as part of an IV cancer chemotherapeutic regimen (i.e., patient is **not** receiving an IV anti-emetic)?.....  Yes  No
- c. Will the oral anti-emetic be used with other oral anti-emetic medications?.....  Yes  No
1. **If YES**, please list the names of all oral anti-emetics **and** IV chemotherapeutic agents the patient will receive: \_\_\_\_\_
6. Is the requested medication used in a nebulizer?.....  Yes  No
- A. **If YES**, please answer the following questions:
- i. Is the patient currently in a Skilled Nursing Facility or hospital?.....  Yes  No
- a. **If YES**, has the patient exhausted all Medicare Part A benefits?.....  Yes  No
7. Is the requested medication an immunosuppressant related to organ transplant?.....  Yes  No
- A. **If YES**, please answer the following questions:
- i. Please indicate the organ transplanted: \_\_\_\_\_
- ii. Please provide the date of the transplant: \_\_\_\_/\_\_\_\_/\_\_\_\_
- iii. Did Medicare cover the transplant?.....  Yes  No
- B. **If kidney transplant**, please answer the following questions:
- i. Was end stage renal disease the sole reason the patient was enrolled in Medicare?.....  Yes  No
8. Is the requested medication related to End Stage Renal Disease (ESRD)?.....  Yes  No
- A. **If YES**, is the patient currently receiving dialysis?.....  Yes  No
9. Is the requested medication insulin?.....  Yes  No
- A. **If YES**, please answer the following questions:
- i. Is the insulin used in an insulin pump?.....  Yes  No
- a. **If YES**, is it a non-disposable insulin pump?.....  Yes  No
10. Please list the names of all medications (including insulins) previously tried and failed or to which the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to related to this request: \_\_\_\_\_
11. Additional information we should consider (attach any supporting documents): \_\_\_\_\_

**PLEASE CONTINUE TO NEXT PAGE**



**BlueCross BlueShield  
of North Carolina**

## **Medicare Part B vs. Medicare Part D Drug Request Form**

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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