BlueCross BlueShield of North Carolina

Compound Prescriptions
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:

Additional Required Information	
Compound Name:	Diagnosis Code:
Route of Administration: ☐ Topical ☐ Oral ☐ IV ☐ Other (please specify):_____	
Compounding Pharmacy Name:	Compounding Pharmacy Phone Number:

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 list ALL ingredients in the compounded prescription:

	Ingredient Name	Strength	Formulation (i.e. tab, cream, solution, etc.)
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			

PLEASE CONTINUE TO NEXT PAGE

BlueCross BlueShield of North Carolina

Compound Prescriptions
Exception Request Form

3. Please list the names **and** strengths of all medications previously tried and failed, or to which the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to related to the diagnosis (please specify if the product was brand-name, generic, or over-the-counter): _____
_____
_____

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: _____

.

Updated: 01/01/2022