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

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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: _____

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Updated: 01/01/2023