

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			
Medication Requested:		Diagnosis Code:	
Strength and Route of Administration:		Dosing Schedule:	
Quantity per 30 days:			
Please answer questions below			
<p><b>PLEASE NOTE:</b></p> <ul style="list-style-type: none"> <li>Medications on the specialty tier are not eligible for a tier exception.</li> <li>Tier exceptions for brand name medications will be approved to the lowest tier which contains brand name alternatives.</li> <li>Tier exceptions for biological products will be approved to the lowest tier which contains biological alternatives.</li> <li>Tier exceptions for generic medications will be approved to the lowest tier which contains generic alternatives.</li> <li>Tier exception requests cannot be considered for medications that do not have an alternative available on a lower tier (e.g., levothyroxine tablets).</li> <li>Tier exception requests cannot be considered for medications that have been approved as a formulary exception.</li> <li>See Evidence of Coverage (EOC) for more information.</li> </ul>			
<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:</b></p> <p style="margin-left: 20px;">i. Please provide the treatment start date of the requested medication: ___/___/___</p> <p style="margin-left: 20px;">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 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>			
<b>PLEASE CONTINUE TO NEXT PAGE</b>			



5. Is the requested medication 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: \_\_\_\_\_