

To submit request electronically, please go to 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:			
Please answer questions below			
Certain medications 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 https://www.cms.gov/medicare-coverage-database/ or DME-MAC Jurisdiction C http://www.cgsmedicare.com/jc/coverage/lcdinfo.html for Part B drug coverage clarification).			
1. Is this request for an expedited review?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <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>			
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. If YES, please answer question 5 on next page. 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. If YES, please specify condition: _____			
PLEASE CONTINUE TO NEXT PAGE			

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 medications the patient will receive: _____
- b. Is it likely that the anti-cancer medication 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 medication is given?..... Yes No
1. **If YES**, will the patient take the oral anti-emetic after the oral anti-cancer medication 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 medications 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 medications 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
8. 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 disposable insulin pump (such as Omnipod or V-go)?..... Yes No
9. Is the requested medication related to End Stage Renal Disease (ESRD)?..... Yes No
- A. **If YES**, is the patient currently receiving dialysis?..... Yes No
10. Is the requested medication a vaccination for Hepatitis B (such as Engerix-B or Recombivax)?..... Yes No
- A. **If YES**, is the patient at high or intermediate risk of contracting hepatitis B (such as an individual with ESRD or hemophilia, or a health care professional)?..... Yes No
11. Is the requested medication a vaccination for Tetanus (such as Tenivac or TDVAX)?..... Yes No
- A. **If YES**, is the need for a tetanus vaccine related to an injury or direct exposure to tetanus?..... Yes No

PLEASE CONTINUE TO NEXT PAGE



12. 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: _____

13. Additional information we should consider (attach any supporting documents): _____

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: _____