



TIER AND NONFORMULARY DRUG REQUEST FORM
(Incomplete form may delay processing)

Table with 2 main columns: Prescriber Information and Patient Information. Includes fields for Physician Name, Office Contact Person, Office Phone/Fax, Address, City/State/Zip, Patient Name, Patient ID, Home Phone, Sex, and DOB.

FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

Patient's Diagnosis: _____

Medication Requested (name, strength, dosage form of drug): _____

- Tier and nonformulary exception requests: Member must have tried and failed the generic equivalent for the requested drug, if one is available, AND at least one preferred (Tier 1 or 2) alternative drug, OR the alternative Part D drugs would not be as effective in treating the member's condition and/or would cause the member to have adverse effects (evidence required).
Tier exception requests are only permitted from Tier 3 to Tier 2 (see Evidence of Coverage).

1. Generic equivalent tried: Has the member been prescribed the generic equivalent for the requested drug?
[] YES [] NO [] There is no generic for this brand.

If YES, length of therapy: _____

Was the generic equivalent ineffective or did the member experience adverse effects? Please explain:

AND

2. Preferred alternatives tried: Has member been prescribed at least one of the preferred generic or brand drugs (Tier 1 or 2) in the same drug class or therapeutic category as the requested drug? [] YES [] NO

If YES, name of drug(s) and length of therapy: _____

Were the drug(s) ineffective or did the member experience adverse effects? Please explain:

OR

3. If, in your opinion, the alternative Part D drugs would not be as effective in treating the member's condition and/or would cause the member to have adverse effects, please supply clinical evidence or supporting medical documentation for expected differences in efficacy and/or adverse effects between therapeutically similar alternative products. (Evidence required before determination can be made.)

I certify that, to the best of my knowledge, the above information is accurate.

Physician Signature: _____ Date: _____

Please Return Completed Form to: Fax number: 1-888-446-8535

Address: BCBSNC

Attention: Exceptions-Healthcare Services

P.O. Box 17509, Winston-Salem, NC 27116-7509

Provider Line Telephone: 1-888-296-9790