



**TIER AND NONFORMULARY DRUG REQUEST FORM**

(Incomplete form may delay processing)

Prescriber Information		Patient Information	
Physician Name:		Patient Name:	
Office Contact Person:		Patient ID # :	
Office Phone # :	Office Fax # :	Home Phone # :	
Address:		Sex (circle): M F	DOB:
City:	State:	Zip:	

**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: 1-888-446-8440  
 Address: BCBSNC  
 Attention: Exceptions-Healthcare Services  
 P.O. Box 17168  
 Winston-Salem, NC 27116-7168  
 Provider Line Telephone: 1-888-298-7552

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