



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.
- Tier exception requests are only permitted from Tier 3 to Tier 2 (see Evidence of Coverage).

1. Generic alternatives tried: Has the member been prescribed at least one generic drug in the same therapeutic class or category as the requested drug? YES NO There is no generic in this class or category.

If YES, name of generic drugs and length of therapy: _____

How did member react to generic drug? _____

AND

2. Brand alternatives tried: Has member been prescribed at least one of the preferred brand drugs (Tier 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? Please explain: _____

OR

Did member experience adverse effects from the drug(s) or are adverse effects expected with the use of an alternative? Please describe: _____

OR

Please supply **clinical evidence** or supporting medical documentation for expected differences in efficacy and/or adverse effects between therapeutically equivalent products.

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-Health Services
 P.O. Box 17168
 Winston-Salem, NC 27116-7168
 Provider Line Telephone: 1-888-298-7552

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