RESTRICTED-ACCESS DRUGS CERTIFICATION FAXBACK

FAX BOTH PAGES – INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

The nonpreferred drugs listed below require physician written certification. Coverage will be limited to the respective preferred drugs unless written certification is provided by the physician stating that the patient meets the specific criteria listed in the signature box on page two.

Dx Code: ____________________

TRIPTANS – Use Triptan Restricted-Access and Quantity Limitations Fax Request Form

SSRIs AND SNRI – Use Anti-Depressant Restricted Access Certification Faxback Form

NONPREFERRED DRUG REQUESTED	PREFERRED DRUG(S) TRIED
DORYX® (doxycycline hyclate delayed-release) NONPREFERRED DRUG REQUESTED: __ Doryx (brand-name doxycycline hyclate delayed-release) 75, 100, 150 mg tablets	**PREFERRED DRUG(S) TRIED (Check at least one):** __ generic doxycycline tablets or capsules* __ minocycline 50, 75, 100 mg capsules (generic Dynacin®, Minocin®); 50, 75, 100 mg tablets
*Generic doxycycline includes immediate-release doxycycline hyclate 50, 100 mg tablets, capsules (generic Vibramycin®, Vibra-Tabs®), delayed-release 75, 100 mg tablets (generic Doryx) OR immediate-release doxycycline monohydrate (generic) 50, 75, 100, 150 mg tablets, capsules	
SOLODYN® (minocycline extended-release) NONPREFERRED DRUG REQUESTED: __ Solodyn (brand-name minocycline extended-release) 45, 55, 65, 80, 90, 105, 115, 135 mg tablets	**PREFERRED DRUG TRIED:** __ minocycline 50, 75, 100 mg capsules (generic Dynacin, Minocin); 50, 75, 100 mg tablets
ANGIOTENSIN RECEPTOR BLOCKERS (ARBs) NONPREFERRED DRUG REQUESTED: __ Atacand® or Atacand HCT® __ Avapro® or Avalide® __ Benicar® or Benicar HCT® __ Edarbi® (effective 7/1/11) __Edarbyclor®	**PREFERRED DRUG(S) TRIED (Check at least one):** __ losartan (generic or brand Cozaar®) or losartan/HCTZ (generic or brand Hyzaar®) __ valsartan (Diovan®) or valsartan/HCTZ (Diovan HCT®) __ telmisartan (Micardis®) or telmisartan/HCTZ (Micardis HCT®) __ eprosartan (Teveten ®) or eprosartan/HCTZ (Teveten HCT®)

RENIN INHIBITORS NONPREFERRED DRUG REQUESTED:	**PREFERRED DRUG(S) TRIED (Check at least one):**
__ Tekturna® __ Tekturna HCT® __ Valturna® __ Tekamlo™ __ Amturnide™ *(effective 3/1/2012)*	__ losartan (generic or brand Cozaar®) or losartan/HCTZ (generic or brand Hyzaar®) __ valsartan (Diovan®) or valsartan/HCTZ (Diovan HCT®) __ telmisartan (Micardis®) or telmisartan/HCTZ (Micardis HCT®) __ eprosartan (Teveten ®) or eprosartan/HCTZ (Teveten HCT®) __ valsartan/amlodipine (Exforge®) or valsartan/amlodipine/HCTZ (Exforge HCT®)
HYPNOTIC AGENTS NONPREFERRED DRUG REQUESTED: __ Edluar® __ Intermezzo® __ Lunesta® __ Silenor® __ Rozerem® __ Zolpimist® *Note: Benefit limits may apply to preferred and nonpreferred hypnotic agents.*	**PREFERRED DRUG(S) TRIED (Check at least one):** __ zolpidem (generic or brand Ambien®) __ zaleplon (generic or brand Sonata®)
PROTON PUMP INHIBITORS NONPREFERRED DRUG REQUESTED: __ Zegerid® packets __ Protonix® 40 mg suspension __ Aciphex® __ Dexilant™ (Kapidex™) __ Prilosec® for oral suspension (packets) __ Lansoprazole powder (powder for compounding only; doesn't include Prevacid brand products) __ Prevacid SoluTabs®	**PREFERRED DRUG(S) TRIED (Check at least one):** __ omeprazole (generic or brand Prilosec®, including Prilosec OTC) __ pantoprazole (generic or brand Protonix®) __ lansoprazole (generic or brand Prevacid®) __ omeprazole/sodium bicarbonate capsules (generic or brand Zegerid®) __ esomeprazole (Nexium®)
INTRANASAL STEROIDS NONPREFERRED DRUG REQUESTED: __ Beconase AQ® __ Omnaris® __ Rhinocort Aqua® __ Veramyst® (Nasacort AQ removed 10/1/11)	**PREFERRED DRUG(S) TRIED (Check at least one):** __ flunisolide (generic or brand Nasarel®) __ fluticasone propionate (generic or brand Flonase®) __ mometasone furoate (Nasonex®) __ triamcinolone acetonide (generic or brand Nasacort®)
ORAL BISPHOSPHONATES NONPREFERRED DRUG REQUESTED: __ Actonel® __ Atelvia® (effective 7/1/11)	**PREFERRED DRUG(S) TRIED (Check at least one):** __ alendronate (generic or brand Fosamax®) __ alendronate / vitamin D3 (Fosamax Plus D®) __ ibandronate (Boniva®)

Please certify the following by signing and dating below:

I certify that the above-referenced patient has previously used at least one of the preferred drugs in the pertinent drug class, as indicated above, and such drug was detrimental to the patient's health or was ineffective in treating the patient's condition and, in my opinion, is likely to be detrimental to the patient's health or ineffective in treating the condition again. I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

*Physician signature: ________________________________ Date: __________________