Copay Waiver for Breast Cancer Prevention Therapy
(Brand Name Soltamox Only)

PLEASE ANSWER THE FOLLOWING QUESTIONS:  

1. Is brand name Soltamox (tamoxifen) oral solution being requested for primary prevention of breast cancer because the patient is high risk? ......................................................... ☐Yes ☐No

2. Does the patient have a prior diagnosis of breast cancer? ................................................. ☐Yes ☐No

3. Does the patient have difficulty swallowing OR cannot swallow generic tamoxifen tablets? ☐Yes ☐No

4. Does the patient have a documented intolerance or hypersensitivity to generic tamoxifen tablets? ........................................................................................................... ☐Yes ☐No

Please certify the following by signing and dating below:

I certify that I have been authorized to request this copay waiver for the above requested service(s). 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.

Prescriber’s Signature (Required): __________________________ Date: __________________

Fax completed form to Corporate Pharmacy at BCBSNC 919-765-7291