

To submit request electronically, please go to
providerportal.surescripts.net/ProviderPortal/login **OR**
covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: 888-446-8535

Mail: Blue Cross NC, ATTN: Part D Coverage Determination
P.O. Box 2251, Durham, NC 27702-2251

Call: 888-298-7552 Blue Medicare Rx
888-296-9790 Blue Medicare HMO/PPO

Incomplete Form May Delay Processing

Prescriber Information		Patient Information
Physician Name:	NPI #:	Patient Name:
Office Contact Person:		Patient ID #:
Office Phone #:	Office Fax #:	Home Phone #:
Address:		Sex: ☐ Female ☐ Male
City:	State: Zip:	DOB:
Diagnosis and Medication Information		
Medication Requested:		Diagnosis Code:
Strength and Route of Administration:		Dosing Schedule:
Quantity per 30 days:		
Please answer questions below		
PLEASE NOTE: - Medications on the specialty tier are not eligible for a tier exception. - Tier exceptions for brand name medications will be approved to the lowest tier which contains brand name alternatives. - Tier exceptions for biological products will be approved to the lowest tier which contains biological alternatives. - Tier exceptions for generic medications will be approved to the lowest tier which contains generic alternatives. - Tier exception requests cannot be considered for medications that do not have an alternative available on a lower tier (e.g., levothyroxine tablets). - Tier exception requests cannot be considered for medications that have been approved as a formulary exception. - See Evidence of Coverage (EOC) for more information.		
1. Is this request for an expedited review?..... ☐ Yes ☐ No <i>Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. A standard review will have a decision made within 72 hours for a coverage determination.</i>		
2. Please indicate if the requested medication is a: ☐ brand-name product ☐ generic product		
3. Is the patient currently taking the requested medication?..... ☐ Yes ☐ No A. If YES, please answer the following: i. Please provide the treatment start date of the requested medication: ____/____/____ ii. Is the patient currently taking a <i>lower dose</i> of the requested medication (e.g., currently taking 30 mg, request is for 60 mg)?..... ☐ Yes ☐ No		
4. Please list the names and strengths of all medications previously tried and failed (please specify if the product was brand-name, generic, or over-the-counter), or to which the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to related to this diagnosis. (Please include any additional clinical rationale for requesting this exception). _____ _____ _____		
PLEASE CONTINUE TO NEXT PAGE		

5. Is the requested medication a **high-risk medication** (please refer to the patient's formulary)?..... ☐ Yes ☐ No

A. **If YES**, please answer the following:

i. Is the patient *at least* 65 years of age?..... ☐ Yes ☐ No

ii. Do the benefits of the requested high-risk medication outweigh the risks for this patient?..... ☐ Yes ☐ No

iii. Has the prescriber documented that the potential side effects and risks of this high-risk medication have been discussed with the patient or authorized representative of the patient?.... ☐ Yes ☐ No

I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature: _____ Date: _____