

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

NOTE: Please refer to the patient's formulary for program quantity limits.

1. Is this request for an expedited review?..... ☐ Yes ☐ No
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.

2. Can the prescribed total daily dose be achieved with a lower quantity of a higher strength that does not exceed the quantity limit (e.g., one 60 mg tablet/day in place of two 30 mg tablets/day)?..... ☐ Yes ☐ No

3. Please list the names **AND** strengths of all medications (including other strengths or doses of the requested medication) the patient has previously tried and failed, or had an inadequate response, related to this diagnosis: _____

4. Please provide clinical rationale in support of the quantity requested, including length of time the requested dose has been used (may submit medical records to support this request): _____

PLEASE CONTINUE TO NEXT PAGE

5. Is the requested medication an opioid?..... ☐ Yes ☐ No
- A. **If YES**, is the patient currently (within the past 90 days) being treated with opioids?..... ☐ Yes ☐ No
- i. **If NO**, does the patient require more than a 7 days' supply of the requested medication?..... ☐ Yes ☐ No
- If YES**, please answer the following questions:
- a. Is the requested medication being used to treat cancer-related pain? ☐ Yes ☐ No
- b. Is the requested medication being used to treat sickle cell disease-related pain? ☐ Yes ☐ No
- c. Does the patient reside in a long-term care facility?..... ☐ Yes ☐ No
- d. Is the patient in hospice or receiving palliative or end-of-life care?..... ☐ Yes ☐ No
1. **If NO**, please provide a clinical rationale in support of an extended duration (beyond a 7 days' supply), including length of time the requested medication will be used (may submit medical records to support this request):
- _____
- _____
- _____
- B. Is the patient currently being treated with a benzodiazepine at the same time as the requested medication?..... ☐ Yes ☐ No
- i. **If YES**, please provide a clinical rationale in support of the concurrent use of a benzodiazepine with the requested medication: _____
- _____
- _____
6. Is the request for the preferred diabetic test strips (Ascensia Contour)? ☐ Yes ☐ No
- A. Is the quantity requested greater than the set quantity limit of #204 test strips per 30 days?..... ☐ Yes ☐ No
- i. **If YES**, does the patient use an insulin pump?..... ☐ Yes ☐ No
- a. **If YES**, please specify the particular product (such as Omnipod, Medtronic): _____
- _____
- ii. **If YES to 6.A.**, please provide a clinical rationale in support of the quantity requested, including how often the patient is testing their blood sugar (may submit medical records to support this request): _____
- _____
- _____
7. Is the request for a preferred (Dexcom or Freestyle Libre) continuous glucose monitor (CGM)? ☐ Yes ☐ No
- A. Is the quantity requested greater than the set quantity limit (see QL table in criteria document)? ☐ Yes ☐ No
- i. **If YES**, please provide a clinical rationale in support of the quantity requested (may submit medical records to support this request): _____
- _____
- _____

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: _____