REQUEST FOR WAIVER OF BRAND DRUG ADDITIONAL FEES

PRIOR REVIEW/CERTIFICATION FAXBACK FORM
INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5 DIGIT Blue Cross NC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]

CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX

PRESCRIBER ADDRESS	CITY	STATE	ZIP

PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER
			M F

PLEASE ANSWER THE FOLLOWING QUESTIONS: **Diagnosis Code:_____**

Brand Drug Name: _____

1. Has the prescriber indicated "Dispense As Written" on the prescription?…….…… ☐ Yes ☐ No
2. Has the patient tried an A-rated generic equivalent to the brand prescribed?.....…...☐ Yes ☐ No
3. Does the patient have a documented allergic reaction to an inactive ingredient that is present in the generic formulation, but absent in the brand name equivalent?.....…...☐ Yes ☐ No
4. Has the patient had a documented life-threatening side effect that required medical intervention to a generic medication that did not occur with the brand name equivalent?.....…….……☐ Yes ☐ No
5. Has the prescriber completed and submitted an FDA MedWatch Adverse Event Reporting Form on behalf of this patient? **(copy must be attached)**…….... ☐ Yes ☐ No

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my 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. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required):_____Date:_____

For Blue Cross NC members, fax form to 1-800-795-9403