BlueCross BlueShield of North Carolina

# Compound Prescriptions
## Exception Request Form

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: |

| Additional Required Information | |
|---|---|
| Compound Name: | Diagnosis Code: |
| Route of Administration: ☐ Topical ☐ Oral ☐ IV ☐ Other (please specify):_____ | |
| Compounding Pharmacy Name: | Compounding Pharmacy Phone Number: |

**Please answer questions below**

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. Please list ALL ingredients in the compounded prescription:

**Ingredient Name** **Strength** **Formulation (i.e. tab, cream, solution, etc.)**

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

**PLEASE CONTINUE TO NEXT PAGE**

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3. Please list the names **and** strengths of all medications previously tried and failed, or to which the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to related to the diagnosis (please specify if the product was brand-name, generic, or over-the-counter): _____
_____
_____

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: _____

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Updated: 01/01/2024