

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: <u>888-446-8535</u>

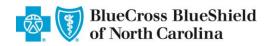
Mail: Blue Cross NC, ATTN: Part D Coverage Determination

P.O. Box 2251, Durham, NC 27702-2251

Call: <u>888-298-7552</u> Blue Medicare Rx

888-296-9790 Blue Medicare HMO/PPO

Incomplete Form May Delay Processing Prescriber Information Patient Information Physician Name: Patient Name: NPI #: Office Contact Person: Patient ID #: Office Phone #: Office Fax #: Home Phone #: Sex: □ Female □ Male Address: City: State: Zip: DOB: **Additional Required Information** Compound Name: Diagnosis Code: Route of Administration: ☐ Topical ☐ Other (please specify):_____ □ Oral □ IV 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** Strenath Formulation (i.e. tab, cream, solution, etc.) PLEASE CONTINUE TO NEXT PAGE



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3.	. Please list the names <u>and</u> strengths of all medications previously tried and failed has a documented intolerance, FDA labeled contraindication, or hypersensitivity diagnosis (please specify if the product was brand-name, generic, or over-the-co	to related to the	
11	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.		
Ρ	hysician Signature:	_ Date:	