

**Part D Coverage Determination Form
Exception Request and Prior Authorization
(Incomplete Form May Delay Processing)**

Prescriber Information		Patient Information	
Physician Name:		Patient Name:	
Office Contact Person:		Patient ID # :	
Office Phone # :	Office Fax # :	Home Phone # :	
Address:		Sex (circle): M F	DOB:
City:	State:	Zip:	
Diagnosis and Medical Information			
Medication:	Strength and Route of Administration:		Frequency:
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:		Qty:
Diagnosis:			
Rationale for Exception Request or Prior Authorization FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION			
<p><input type="checkbox"/> Prior Authorization Request: Part D coverage of certain drugs is available only if coverage is not available under Part B. (See http://www.cignagovernmentservices.com/partb/coverage/index.html#policies for Part B coverage clarification).</p> <p>➔ Specify at REQUIRED EXPLANATION below Clinical Reasons drug covered under Part D drug benefit:</p>			
<p><input type="checkbox"/> Non-Formulary Request: Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure)</p> <p>➔ Specify at REQUIRED EXPLANATION below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);</p> <p>Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with the medication change</p> <p>➔ Specify at REQUIRED EXPLANATION below: Anticipated significant adverse clinical outcome</p>			
<p><input type="checkbox"/> Other Request: _____</p> <p>➔ Explain below at REQUIRED EXPLANATION</p> <p>REQUIRED EXPLANATION: _____</p> <p>_____</p>			
<p>I certify that, to the best of my knowledge, the above information is accurate.</p> <p>Physician Signature: _____</p>			

Please Return Completed Form to: Fax number: 1-888-446-8535
Address: BCBSNC, Attention: Exceptions-Health Services
P.O. Box 17509, Winston-Salem, NC 27116-7509
Provider telephone: 1-888-296-9790

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