

Non-Formulary 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

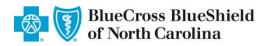
Call: 888-298-7552 Blue Medicare Rx

888-296-9790 Blue Medicare HMO/PPO

Incomplete Form May Delay Processing Prescriber Information Patient Information NPI#: Physician Name: Patient Name: Office Contact Person: Patient ID #: Office Phone #: Home Phone #: Office Fax #: Address: Sex: ☐ Female ☐ Male DOB: City: State: Zip: **Diagnosis and Medication Information** Medication Requested: Diagnosis Code: Strength and Route of Administration: Dosing Schedule: Quantity per 30 Days: Please answer questions below 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 indicate if the requested medication is a: ☐ brand-name product ☐ generic product 3. Is the patient currently taking the requested medication? □ Yes □ No A. **If YES**, please answer the following questions: i. Please provide the treatment start date of the requested medication: ___/___/ ii. Is the patient currently taking a lower dose of the requested medication (e.g., currently taking 30 mg, request is for 60 mg)?...... ☐ Yes ☐ No iii. If there is high risk of adverse clinical outcome with a change in therapy please specify the anticipated adverse outcome and provide any clinical evidence available to support this: 4. Please list the names **AND** strengths of all medications related to this diagnosis previously tried and failed (please specify if the product was brand-name, generic, or over-the-counter) or to which the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity: 5. **For high-risk medications only** (please refer to the patient's formulary): A. Is the patient *at least* 65 years of age? □ Yes □ No B. Do the benefits of the requested high-risk medication outweigh the risks for this patient? ☐ Yes ☐ No C. Has the prescriber documented that the risks and potential side effects of this high-risk medication have been discussed with the patient or authorized representative of the patient? ☐ Yes ☐ No

PLEASE CONTINUE TO NEXT PAGE

Updated: 10/18/2024



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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: