BlueCross BlueShield of North Carolina

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: 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:

Diagnosis and Medication Information	
Medication Requested:	Diagnosis Code:
Strength and Route of Administration:	Dosing Schedule:
Quantity per 30 Days:	

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 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

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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: _____

Updated: 10/18/2024