

To submit request electronically, please go to [covermy meds.com](http://covermy meds.com) using Plan/PBM Name "BCBS NC"

Fax: 888-446-8535

Mail: Blue Cross NC, ATTN: Part D Coverage Determination  
P.O. Box 17509, Winston Salem, NC 27116-7509

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: <input type="checkbox"/> Female <input type="checkbox"/> Male		
City:	State:	Zip:	DOB:		
Diagnosis and Medication Information					
Medication Requested:			Diagnosis Code:		
Strength and Route of Administration:					
Please answer questions below					
<p>Certain medications may be covered under Medicare Part B or Medicare Part D and therefore, require prior review to determine the entity responsible for coverage (see CMS Coverage database <a href="https://www.cms.gov/medicare-coverage-database/">https://www.cms.gov/medicare-coverage-database/</a> or DME-MAC Jurisdiction C <a href="http://www.cgsmedicare.com/jc/coverage/lcdinfo.html">http://www.cgsmedicare.com/jc/coverage/lcdinfo.html</a> for Part B drug coverage clarification).</p>					
<p>1. Is this request for an expedited review?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>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.</i></p>					
<p>2. Please indicate if the requested medication is a:  <input type="checkbox"/> brand-name product      <input type="checkbox"/> generic product</p>					
<p>3. Will the requested medication be administered by a healthcare professional and billed under the Part B (medical) benefit (including "buy-and-bill")?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  A. <b>If NO</b>, will the requested medication be self-administered by the patient OR billed under the Part D (pharmacy) benefit?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  i. <b>If NO</b>, please provide explanation of how the requested medication will be billed and administered to the patient: _____  _____</p>					
<p>4. Is the requested medication an oral anti-emetic being prescribed for nausea and/or vomiting related to any of the following conditions?</p> <p>A. Chemotherapy-induced nausea/vomiting..... <input type="checkbox"/> Yes <input type="checkbox"/> No  i. <b>If YES, please answer question 5 on next page.</b></p> <p>B. Post-operative nausea/vomiting..... <input type="checkbox"/> Yes <input type="checkbox"/> No  C. Medication-induced nausea/vomiting..... <input type="checkbox"/> Yes <input type="checkbox"/> No  D. Radiation-induced nausea/vomiting..... <input type="checkbox"/> Yes <input type="checkbox"/> No  E. Other..... <input type="checkbox"/> Yes <input type="checkbox"/> No  i. <b>If YES, please specify condition:</b> _____  _____</p>					
<b>PLEASE CONTINUE TO NEXT PAGE</b>					

5. For oral anti-emetics prescribed for chemotherapy-induced nausea/vomiting, please answer the following questions:
- A. Is the patient receiving **oral chemotherapy**?.....  Yes  No
- i. **If YES**, please answer the following questions:
- a. List the names of all oral chemotherapeutic medications the patient will receive: \_\_\_\_\_
- b. Is it likely that the anti-cancer medication will cause vomiting if the requested oral anti-emetic is not given?.....  Yes  No
- c. Will the patient receive the oral anti-emetic within 2 hours before the oral anti-cancer medication is given?.....  Yes  No
1. **If YES**, will the patient take the oral anti-emetic after the oral anti-cancer medication is given?.....  Yes  No
- B. Is the patient receiving **IV chemotherapy**?.....  Yes  No
- i. **If YES**, please answer the following questions:
- a. Will the patient receive the oral anti-emetic within 2 hours of chemotherapy administration?.....  Yes  No
1. **If YES**, will the patient take the oral anti-emetic beyond 48 hours of receiving chemotherapy?.....  Yes  No
- b. Will the oral anti-emetic be used as a full therapeutic replacement for IV anti-emetic medications as part of an IV cancer chemotherapeutic regimen (i.e., patient is **not** receiving an IV anti-emetic)?.....  Yes  No
- c. Will the oral anti-emetic be used with other oral anti-emetic medications?.....  Yes  No
1. **If YES**, please list the names of all oral anti-emetics **and** IV chemotherapeutic medications the patient will receive: \_\_\_\_\_
6. Is the requested medication used in a nebulizer?.....  Yes  No
- A. **If YES**, please answer the following questions:
- i. Does the patient have a diagnosis of COPD or asthma?.....  Yes  No
- a. **If NO**, please specify diagnosis: \_\_\_\_\_
- ii. Is the patient currently in a Skilled Nursing Facility or hospital?.....  Yes  No
- a. **If YES**, has the patient exhausted all Medicare Part A benefits?.....  Yes  No
7. Is the requested medication an immunosuppressant related to organ transplant?.....  Yes  No
- A. **If YES**, please answer the following questions:
- i. Please indicate the organ transplanted: \_\_\_\_\_
- ii. Please provide the date of the transplant: \_\_\_\_/\_\_\_\_/\_\_\_\_
- iii. Did Medicare cover the transplant?.....  Yes  No
8. Is the requested medication insulin?.....  Yes  No
- A. **If YES**, please answer the following questions:
- i. Is the insulin used in an insulin pump?.....  Yes  No
- a. **If YES**, is it a disposable insulin pump (such as Omnipod or V-go)?.....  Yes  No
9. Is the requested medication related to End Stage Renal Disease (ESRD)?.....  Yes  No
- A. **If YES**, is the patient currently receiving dialysis?.....  Yes  No
10. Is the requested medication a vaccination for Hepatitis B (such as Engerix-B or Recombivax)?.....  Yes  No
- A. **If YES**, is the patient at high or intermediate risk of contracting hepatitis B (such as an individual with ESRD or hemophilia, or a health care professional)?.....  Yes  No
11. Is the requested medication a vaccination for Tetanus (such as Tenivac or TDVAX)?.....  Yes  No
- A. **If YES**, is the need for a tetanus vaccine related to an injury or direct exposure to tetanus?.....  Yes  No

**PLEASE CONTINUE TO NEXT PAGE**



12. Please list the names of all medications (including insulins) previously tried and failed or to which the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to related to this request: \_\_\_\_\_  
\_\_\_\_\_

13. Additional information we should consider (attach any supporting documents): \_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

Blue Cross and Blue Shield of North Carolina is a HMO/PPO/PDP plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.