

To submit request electronically, please go to covermymeds.com using Plan/PBM Name “BCBS NC”

Fax: [888-446-8535](tel:888-446-8535)

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

Call: [888-296-9790](tel:888-296-9790) Blue Medicare HMO/PPO

Incomplete Form May Delay Processing

Prescriber Information		Patient Information	
Physician Name:		NPI #:	
Office Contact Person:		Patient Name:	
Office Phone #:		Patient ID #:	
Office Fax #:		Home Phone #:	
Address:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
City:	State:	Zip:	DOB:

Diagnosis and Medication Information

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

Please answer questions below

THIS FORM IS FOR A MEDICARE PART B (MEDICAL) REQUEST ONLY

- 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.
- Please indicate the requested brand of diabetes testing supplies:
 Accu-Chek FreeStyle ReliOn True Metrix
 Other (please specify): _____
- Does the patient have diabetes, prediabetes, or gestational diabetes?..... Yes No
 A. **If NO**, has the patient been treated with a diabetes medication within the past 90 days?..... Yes No
 i. **If NO to 3.A.**, has the patient been treated with a concomitant drug that may affect blood sugar levels within the past 90 days?..... Yes No
- Does the patient use an insulin pump?..... Yes No
 A. **If YES**, please specify the particular product (such as Omnipod, Medtronic): _____

- Does the patient use a continuous glucose monitor?..... Yes No
 A. **If YES**, please specify the particular product (such as Dexcom, Freestyle Libre): _____

- Has the patient tried Ascensia (Contour) brand diabetes testing supplies?..... Yes No
 A. **If NO**, what limitations does this patient have precluding the use of this covered brand (include any additional clinical rationale for requesting coverage)?:

PLEASE CONTINUE TO NEXT PAGE

7. Has the patient tried Lifescan (OneTouch) brand diabetes testing supplies?..... Yes No
A. **If NO**, what limitations does this patient have precluding the use of this covered brand (include any additional clinical rationale for requesting coverage)?:

8. Is the quantity requested *greater* than the set quantity limit of #204 test strips per 30 days?..... Yes No
A. **If YES**, please provide a clinical rationale in support of the quantity requested, including how often the patient is testing their blood sugar (may submit medical records to support this request):

I certify that I have appropriate authority to request a coverage decision 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: _____