BlueCross BlueShield of North Carolina

ACA COPAY WAIVER

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]	
CONTACT PERSON	**PRESCRIBER PHONE**	**PRESCRIBER FAX**	
PRESCRIBER ADDRESS	**CITY**	**STATE**	**ZIP**
PATIENT NAME	**Blue Cross NC ID**	**DATE OF BIRTH**	**GENDER**
			M F

Select medications are available with no cost sharing for members. These drugs and more information can be found at http://www.BlueCrossNC.com/preventive. If a member cannot use these medications for medical reasons, a copay waiver can be requested for another drug with this form.

This form is NOT a request for a FORMULARY EXCEPTION of a drug that is not covered on the member's formulary.

Please answer the following questions: **Diagnosis Code: _____**

1. Is the request for brand name Soltamox (tamoxifen) oral solution?..... ☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Is the patient utilizing the requested medication for primary prevention of breast cancer because the patient is high risk? ..... ☐ Yes ☐ No
   b. Does the patient have a prior diagnosis of breast cancer?..... ☐ Yes ☐ No
   c. Does the patient have difficulty swallowing or cannot swallow generic tamoxifen tablets?... ☐ Yes ☐ No
   d. Does the patient have a documented intolerance or hypersensitivity to generic tamoxifen tablets?..... ☐ Yes ☐ No
2. Is the request for Femara (letrozole)?..... ☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Is the patient utilizing the requested medication for primary prevention of breast cancer because the patient is high risk?..... ☐ Yes ☐ No
   b. Does the patient have a prior diagnosis of breast cancer?..... ☐ Yes ☐ No
   c. Is the patient clinically able to utilize the medications available at $0 cost share (anastrozole, tamoxifen, raloxifene)? ..... ☐ Yes ☐ No
3. Is the request for brand name Truvada?..... ☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Is the patient utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV?..... ☐ Yes ☐ No
      If YES, please submit medical record documentation.
   b. Has the patient tried the generic version of the requested medication (generic Truvada)?.. ☐ Yes ☐ No
      i. **If YES,** did the patient have a sub-therapeutic or intolerant response to an inactive ingredient of the generic product that is not present in the brand?..... ☐ Yes ☐ No
      If YES, please submit medical record documentation.
   c. Does the patient have a documented intolerance to an inactive ingredient of the generic product that is not found in the brand?..... ☐ Yes ☐ No
      If YES, please submit medical record documentation.

****NOTE: continued on page 2; please complete and sign page 2 to request copay waiver****

ACA COPAY WAIVER (*continued)*

4. Is the request for Apretude, Descovy, or emtricitabine-tenofovir (generic Truvada)?..... ☐ Yes ☐ No
   a. **IF YES,** is the patient utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV?..... ☐ Yes ☐ No

5. Is the request for one of the following statins: atorvastatin, fluvastatin, fluvastatin ER, lovastatin ER, pitavastatin, rosuvastatin, simvastatin?..... ☐ Yes ☐ No
   If YES, please select the requested medication and answer the following questions:
   - ☐ Atorvastatin 10-80mg per day
   - ☐ Fluvastatin 20-80mg per day
   - ☐ Fluvastatin ER 80mg per day
   - ☐ Lovastatin ER 20-40mg per day
   - ☐ Pitavastatin 1-4mg per day
   - ☐ Rosuvastatin 5-40mg per day
   - ☐ Simvastatin 10-40mg per day

   a. Is the requested statin covered under the pharmacy benefit or has been previously approved by Blue Cross NC?..... ☐ Yes ☐ No
   b. Is the patient clinically unable to utilize the medications available at $0 cost share (pravastatin or lovastatin)?..... ☐ Yes ☐ No
   c. Is the patient 40-75 years of age?..... ☐ Yes ☐ No
   e. Does the patient have any of the following risk factors?
      i. Dyslipidemia..... ☐ Yes ☐ No
      ii. Diabetes..... ☐ Yes ☐ No
      iii. Hypertension..... ☐ Yes ☐ No
      iv. Smoking..... ☐ Yes ☐ No
   f. Does the patient have a calculated 10-year risk of a cardiovascular event of 10% or greater per the American College of Cardiology and American Heart Association's Atherosclerotic Cardiovascular Disease (ASCVD) calculator?..... ☐ Yes ☐ No

6. Is the request for a contraceptive medication / device?..... ☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Please list the requested contraceptive medication / device: _____
   b. Is the requested medication/device covered under the pharmacy benefit or has it been previously approved by BlueCross NC?..... ☐ Yes ☐ No
   c. Is the provider requesting the non-preferred version of the prescribed contraceptive based on a determination of medical necessity?..... ☐ Yes ☐ No

7. Is the request for a bowel preparation medication?..... ☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Please list the requested bowel preparation medication: _____
   b. Is the requested medication covered under the pharmacy benefit or has it been previously approved by Blue Cross NC?..... ☐ Yes ☐ No
   c. Is the patient clinically unable to utilize the medications available at $0 cost share?..... ☐ Yes ☐ No

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my 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. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-800-795-9403