BlueCross BlueShield of North Carolina

Medicare Part B vs. Medicare Part D
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:	

Please answer questions below

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 https://www.cms.gov/medicare-coverage-database/ or DME-MAC Jurisdiction C http://www.cgsmedicare.com/jc/coverage/lcdinfo.html for Part B drug coverage clarification).

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. Will the requested medication be administered by a healthcare professional and billed under the Part B (medical) benefit (including "buy-and-bill")?..... ☐ Yes ☐ No
   A. **If NO**, will the requested medication be self-administered by the patient OR billed under the Part D (pharmacy) benefit?..... ☐ Yes ☐ No
      i. **If NO,** please provide explanation of how the requested medication will be billed and administered to the patient:_____
      _____

4. Is the requested medication an oral anti-emetic being prescribed for nausea and/or vomiting related to any of the following conditions?
   A. Chemotherapy-induced nausea/vomiting…….…….. ☐ Yes ☐ No
      i. **If YES, please answer question 5 on next page**.
   B. Post-operative nausea/vomiting……..…… ☐ Yes ☐ No
   C. Radiation-induced nausea/vomiting……..…. ☐ Yes ☐ No
   D. Other……..…. ☐ Yes ☐ No
      i. **If YES, please specify condition:** _____

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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/bone marrow transplant? ☐ Yes ☐ No
    - A. **If YES**, please answer the following questions:
        - i. Please indicate the type of transplant: _____
        - ii. Please provide the date of the transplant: _____/_____/_____
        - iii. Did the member have Medicare Part A at the time of 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. Will the requested medication be used in an external infusion pump (e.g., antifungal, antiviral, chemotherapy, narcotic pain medications, etc.)? ☐ Yes ☐ No
    - A. **If YES,** will the medication be administered in the home? ☐ Yes ☐ No

10. Is the requested medication related to End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
    - A. **If YES**, is the patient currently receiving dialysis? ☐ Yes ☐ No

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11. 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
        i. **If NO,** is the patient's vaccination status known? ☐ Yes ☐ No
            a. **If YES**, has the patient received a completed Hepatitis B vaccination series? ☐ Yes ☐ No

12. 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

13. 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: _____
_____

14. 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: _____

Updated: 04/01/2025