BlueCross BlueShield of North Carolina

NONFORMULARY EXCEPTION REQUEST or VALUE PRIOR AUTHORIZATION

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

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

PLEASE ANSWER THE FOLLOWING QUESTIONS: **Diagnosis Code: _____**

Drug Name: _____ **Strength: _____**

Dosage Form: _____ **Quantity Requested:_____ Per: _____**

1. Has the patient taken the requested medication in the past 180 days?.....☐ Yes ☐ No
2. Is the requested medication being used to treat a seizure related or refractory psychiatric disorder?.....☐ Yes ☐ No
   If YES, please answer the following questions and submit medical record documentation:
   a. Is the patient stable on the requested medication?.....☐ Yes ☐ No
   b. Is the patient's condition too critical to try other medications?.....☐ Yes ☐ No
3. Is the request for a contraceptive medication / device?.....☐ Yes ☐ No
   a. **If YES,** is the provider requesting the non-preferred version of the prescribed contraceptive based on a determination of medical necessity?.....☐ Yes ☐ No
4. Please provide indication for the requested medication: _____
5. Is the requested medication and/or dose considered medically necessary and appropriate for treating the condition?.....☐ Yes ☐ No
6. Is the requested medication treating a chronic, disabling, or life-threatening disease?.....☐ Yes ☐ No
7. Is the requested medication a BRAND medication with an FDA approved A-rated generic equivalent?.....☐ Yes ☐ No
   a. **If YES,** has the patient tried the generic product of the requested medication?.....☐ Yes ☐ No
      If YES, please answer the following questions:
      i. Did the patient have a life-threatening side effect to the generic that required medical intervention that is not anticipated with the brand product?.....☐ Yes ☐ No
      ii. Did the prescriber complete and submit an FDA MedWatch Adverse Event Reporting form?.....☐ Yes ☐ No
      If YES, please provide a copy of the completed MedWatch form.

****Please note: continued on page 2, please complete and sign page 2 for prior authorization request****

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NONFORMULARY EXCEPTION REQUEST or VALUE PRIOR AUTHORIZATION *(continued)*

8. Has the patient tried and failed any other medications for this diagnosis?.....☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Were the previously tried alternative medications detrimental to the patient's health or ineffective in the treatment of the disease or condition?.....☐ Yes ☐ No
   b. In the prescribing provider's opinion, would the previously tried alternative medications be detrimental to the patient's health or ineffective in treating the disease or condition again?.....☐ Yes ☐ No
9. Please provide previously tried and failed medications for this diagnosis (*omission of information indicates N/A or none*):

   _____

   _____
10. Please list any medications the member has a contraindication or is intolerant to for this diagnosis (*omission of information indicates N/A or none*):

    _____

    _____
11. Is the requested medication a non-standard formulation (e.g. chew, concentrate, elixir, film, granule, liquid, orally disintegrating tablet (ODT), powder, sprinkle, suspension, syrup)?...☐ Yes ☐ No
    If YES, please answer the following questions:
    a. Is the patient 11 years of age or younger?.....☐ Yes ☐ No
    b. Is the patient unable to take solid dosage forms?.....☐ Yes ☐ No
    c. Is the patient taking any other medications in a solid dosage form?.....☐ Yes ☐ No
    d. Is the patient using an enteral feeding tube?.....☐ Yes ☐ No
       i. **If YES,** can the tablet/capsule formulation be crushed or opened for administration?.....☐ Yes ☐ No
12. Please provide a clinical rationale for the requested medication and address alternatives that have not been tried, but may be clinically inappropriate; may include medical record documentation, laboratory results, and/or other supporting medical documentation (*omission of information indicates N/A or none*):

    _____

    _____

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