BlueCross BlueShield of North Carolina

Coronavirus Disease 2019 (COVID-19)
Drug Cost-Share Waiver Request Form

To submit request electronically, please go to covermymeds.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: ☐ Female ☐ Male
City: State: Zip:		DOB:

Diagnosis and Medication Information	
Drug Requested:	Diagnosis Code:
Strength and Route of Administration:	Dosing Schedule:
Quantity:	

Please answer questions below

PLEASE NOTE:

* This Drug Cost-Share Waiver request form will be used to consider waiver of a member's cost-share associated with drugs used to treat COVID-19.
* This Drug Cost-Share Waiver request form will NOT be used for any other type of request (e.g., Tier Exception, Prior Authorization, etc.).

1. Is this request for a cost-share waiver for drug(s) used in the treatment of a patient with a confirmed diagnosis of COVID-19?..... ☐ Yes ☐ No

2. Please indicate the drug(s) requested and the treatment start date(s):

Drug Name	Start Date
☐ azithromycin	
☐ chloroquine	
☐ hydroxychloroquine	
☐ Other (please specify):	

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: 04/03/2020