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 Viread?..... ☐ 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
   b. Is the member clinically unable to use emtricitabine-tenofovir 200-300mg tablets (generic Truvada)?..... ☐ Yes ☐ No

****NOTE: continued on page 2; must sign page 3 if requesting copay waiver****

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4. Is the request for Descovy?.....☐ 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. Is the member clinically unable to use emtricitabine-tenofovir 200-300mg tablets (generic Truvada)?.....☐ Yes ☐ No
      If YES, please submit medical record documentation.

5. 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
   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

6. Is the request for a low to moderate intensity statin?.....☐ Yes ☐ No
   a. **If YES, please select the requested medication and answer the following questions:**
      ☐ Atorvastatin 10-20mg per day
      ☐ Fluvastatin 20-80mg per day
      ☐ Fluvastatin ER 80mg per day
      ☐ Lovastatin ER 20-40mg per day
      ☐ Pitavastatin 1-4mg per day
      ☐ Rosuvastatin 5-10mg per day
      ☐ Simvastatin 10-40mg per day
   b. Is the requested statin covered under the pharmacy benefit or has been previously approved by Blue Cross NC?.....☐ Yes ☐ No
   c. Is the patient clinically unable to utilize the medications available at $0 cost share (pravastatin or lovastatin)?.....☐ Yes ☐ No
   d. 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

7. Is the request for a brand 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 patient clinically unable to utilize all medications within its designated FDA-approved contraceptive category available at $0 cost share?.....☐ Yes ☐ No

****NOTE: continued on page 3; must sign page 3 if requesting copay waiver****

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8. 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