BlueCross BlueShield of North Carolina

GENERAL AUTHORIZATION - CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

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

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	BCBSNC PROV ID # / TAX ID [out of state only]

CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX

PRESCRIBER ADDRESS	CITY	STATE	ZIP	Formulary Drug? ☐Yes ☐No

PATIENT NAME	BCBSNC ID	DATE OF BIRTH	GENDER
			M F

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

1. PLEASE Complete (PRINT):

Drug Name:_____ Strength: _____

Dosage Form: _____ Quantity Requested: _____

2. Is the patient currently taking this drug? .... ☐ Yes ☐ No
   a. If Yes, please provide the start date of drug: _____

3. **PLEASE PRINT** documentation of all medications that the member has tried for the patient's disease or condition:

	Drug Name/Strength	Duration	Drug was:
i.	_____	_____	☐ Ineffective ☐ Detrimental to patient's health
ii.	_____	_____	☐ Ineffective ☐ Detrimental to patient's health
iii.	_____	_____	☐ Ineffective ☐ Detrimental to patient's health

☐ No previous medications have been tried for this condition

4. Please provide clinical rationale for requested drug (attach any medical record documentation of laboratory results or other supporting medical documentation):

_____
_____
_____

Please certify the following by signing and dating below: I understand that I am requesting restricted acces drug on a BCBSNC formulary or exception for drug excluded from a BCBSNC formulary. I certify that the above-referenced patient has previously used the medications as noted above and such drugs were detrimental to the patient's health or were ineffective in treating the patient's condition and, in my opinion, are likely to be detrimental to the patient's health or ineffective in treating the condition again. I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required)_____ Date _____

For BCBSNC members, fax form to 1-800-795-9403