BlueCross BlueShield of North Carolina

GENERAL AUTHORIZATION/QUANTITY LIMIT EXCEPTION 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 complete the following: **Dx Code**: _____

Drug Name:_____ Strength: _____

Dosage Form: _____ Quantity Requested: _____

1. Is the request for the generic version of the drug requested above? ..... ☐ Yes ☐ No
2. Has the patient taken the medication in the past 180 days? ..... ☐ Yes ☐ No
3. Please document all medications the member has tried for the patient's disease or condition:

Drug Name / Strength	Duration of treatment	Was drug ineffective?	Was drug detrimental to the patient's health?
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

☐ 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 NOTE: If you are prescribing more than the program quantity limit (listed on page 3) please complete and sign page 2.

Please certify the following by signing and dating below: I understand that I am requesting restricted access drug on a Blue Cross NC formulary or exception for drug excluded from a Blue Cross NC 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 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 _____ Date: _____

For Blue Cross NC members, fax form to 1-800-795-9403

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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: Diagnosis Code:_____

Medication Requested:_____

Requested Quantity: _____ per ☐ day ☐ 5 days ☐ 28 days ☐ 30 days

Dosage Requested:_____

****Please enter quantity as a numeric value with one decimal place (ex. 1.0, 1.5)****

In the space provided, please document support for the requested Quantity Limit Exception (this may include documented clinical rationale and/or medical records). **If none, write N/A.**

_____

_____

_____

_____

_____

_____

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

BlueCross BlueShield of North Carolina

QUANTITY LIMITS

Medication	Medication Dosage Form and Strength	Quantity Limit (per day unless otherwise noted)
Accolate® (zafirlukast)	10 mg tablet	2 tablets
Accolate (zafirlukast)	20 mg tablet	2 tablets
Actos® (pioglitazone)	15 mg tablet	1 tablet
Actos (pioglitazone)	30 mg tablet	1 tablet
Actos (pioglitazone)	45 mg tablet	1 tablet
Actoplus Met® (pioglitazone/metformin)	15 mg/500 mg tablet	3 tablets
Actoplus Met (pioglitazone/metformin)	15 mg/850 mg tablet	3 tablets
Actoplus Met XR (pioglitazone/metformin ER)	15 mg/1000 mg tablet	2 tablets
Actoplus Met XR (pioglitazone/metformin ER)	30 mg/1000 mg tablet	1 tablet
Adlyxin®[1] (lixisenatide)	50 mcg/mL prefilled pen	2 pens every 28 days
Adlyxin (lixisenatide)	100 mcg/mL prefilled pen	2 pens every 28 days
Avandamet (rosiglitazone/metformin)	2 mg/500 mg tablet	2 tablets
Avandamet (rosiglitazone/metformin)	2 mg/1000 mg tablet	2 tablets
Avandamet (rosiglitazone/metformin)	4 mg/500 mg tablet	2 tablets
Avandamet (rosiglitazone/metformin)	4 mg/1000 mg tablet	2 tablets
Avandia (rosiglitazone)	2 mg tablet	2 tablets
Avandia (rosiglitazone)	4 mg tablet	2 tablets
Avandia (rosiglitazone)	8 mg tablet	1 tablet
Basaglar Kwikpen (insulin glargine)	3 mL pen	100 mL/30 days
Bydureon (exenatide ER)	2 mg/vial in single dose tray; 4 trays/carton	1 carton (4 trays/4 doses) per 28 days
Bydureon (exenatide ER)	2 mg/pen; 4 trays/carton	1 carton (4 doses) per 28 days
Byetta (exenatide)	5 mcg/dose prefilled pen	1 prefilled pen (60 doses) per 30 days

Byetta (exenatide)	10 mcg/dose prefilled pen	1 prefilled pen (60 doses) per 30 days
Crestor® (rosuvastatin)	5 mg tablets	1½ tablets
Crestor (rosuvastatin)	10 mg tablets	1½ tablets
Crestor (rosuvastatin)	20 mg tablets	1½ tablets
Crestor (rosuvastatin)	40 mg tablets	1 tablet
Daliresp® (roflumilast)	250 mcg tablet	1 tablet
Daliresp (roflumilast)	500 mcg tablet	1 tablet
Duetact® (pioglitazone/glimepiride)	30 mg/2 mg tablet	1 tablet
Duetact (pioglitazone/glimepiride)	30 mg/4 mg tablet	1 tablet
Jentadueto®[1] (linagliptin/metformin)	2.5 mg/500 mg tablet	2 tablets
Jentadueto (linagliptin/metformin)	2.5 mg/850 mg tablet	2 tablets
Jentadueto (linagliptin/metformin)	2.5 mg/1000 mg tablet	2 tablets
Jentadueto®[1] XR (linagliptin/metformin ER)	2.5 mg/1000 mg tablet	2 tablets
Jentadueto XR (linagliptin/metformin ER)	5 mg/1000 mg tablet	1 tablet
Kazano® (alogliptin/metformin)	12.5mg/500mg tablet	2 tablets
Kazano (alogliptin/metformin)	12.5mg/100mg tablet	2 tablets
Lescol® XL (fluvastatin extended release)	80 mg tablets	1 tablet
Levemir (insulin detemir)	100 U/mL: 10 mL vial, 3 mL pen	100 mL per 30 days
Lipitor® (atorvastatin)	10 mg tablets	1½ tablets
Lipitor (atorvastatin)	20 mg tablets	1½ tablets
Lipitor (atorvastatin)	40 mg tablets	1½ tablets
Lipitor (atorvastatin)	80 mg tablets	1 tablet
Mevacor® (lovastatin)	10 mg tablets	2 tablets
Mevacor (lovastatin)	20 mg tablets	2 tablets
Mevacor (lovastatin)	40 mg tablets	2 tablets
Nesina® (alogliptin)	6.25mg tablet	1 tablet
Nesina (alogliptin)	12.5mg tablet	1 tablet
Nesina (alogliptin)	25mg tablet	1 tablet
Niaspan® (niacin ER tablet)	500 mg extended release tablet	1 tablet

Niaspan® (niacin ER tablet)	750 mg extended release tablet	2 tablets
Niaspan® (niacin ER tablet)	1000 mg extended release tablet	2 tablets
Oseni® (alogliptin/pioglitazone)	12.5mg/15mg tablet	1 tablet
Oseni (alogliptin/pioglitazone)	12.5mg/30mg tablet	1 tablet
Oseni (alogliptin/pioglitazone)	12.5mg/45mg tablet	1 tablet
Oseni (alogliptin/pioglitazone)	25mg/15mg tablet	1 tablet
Oseni (alogliptin/pioglitazone)	25mg/30mg tablet	1 tablet
Oseni (alogliptin/pioglitazone)	25mg/45mg tablet	1 tablet
Ozempic (semaglutide)	0.25mg or 0.5mg per dose (2mg/1.5mL), 1.5 mL, 1 pen	1 pen per 28 days
Ozempic (semaglutide)	1mg per dose (2mg/1.5mL) 3mL, 2 pens	2 pens per 28 days
Pravachol™ (pravastatin)	10 mg tablets	1½ tablets
Pravachol (pravastatin)	20 mg tablets	1½ tablets
Pravachol (pravastatin)	40 mg tablets	1½ tablets
Pravachol (pravastatin)	80 mg tablets	1 tablet
Singulair® (montelukast)	10 mg tablet	1 tablet
Singulair (montelukast)	4 mg chewable tablet	1 tablet
Singulair (montelukast)	5 mg chewable tablet	1 tablet
Singulair (montelukast)	4 mg oral granules	1 packet
Sprix (ketorolac nasal spray)	1.7 g bottle	5 bottles/prescription per 5 days
Sprix (ketorolac nasal spray)	1.7 g bottle (5 pack)	1 pack/prescription per 5 days
Steglujan (ertugliflozin/sitagliptin)	5-100 mg	1 tablet
Steglujan (ertugliflozin/sitagliptin)	15-100 mg	1 tablet
Tanzeum (albiglutide)	30 mg single-dose pen	4 pens per 28 days
Tanzeum (albiglutide)	50 mg single-dose pen	4 pens per 28 days
Tradjenta® (linagliptin)	5 mg tablet	1 tablet
Tresiba (insulin degludec)	100 U/mL Pen-Injector	100 mL per 30 days
Tresiba (insulin degludec)	200 U/mL Pen-Injector	100 mL per 30 days
Xofluza™ (baloxavir marboxil)	20 mg tablet	(2 boxes) 4 tablets every 120 days
Xofluza™ (baloxavir marboxil)	40 mg tablet	(2 boxes) 4 tablets every 120 days
Zetia™ (ezetimibe)	10 mg tablets	1 tablet
Zocor® (simvastatin)	5 mg tablets	1½ tablets
Zocor (simvastatin)	10 mg tablets	1½ tablets
Zocor (simvastatin)	20 mg tablets	2 tablets

Zocor (simvastatin)	40 mg tablets	1½ tablets
Zocor (simvastatin)	80 mg tablets	1 tablet
Zyflo (zilueton)	600 mg tablet	4 tablets
Zyflo CR® (zileuton)	600 mg tablet	4 tablets

NOTE: quantity limits apply to both brand and generic formulations

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("Blue Cross NC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

  Blue Cross NC:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.
- If you believe that Blue Cross NC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
  - Blue Cross NC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.
- This Notice and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-206-4697**.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY：1-800-442-7028）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-206-4697 (TTY: 1- 800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. المبرقة الكاتبة: 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:સુલ્કુ ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697（TTY: 1-800-442-7028）まで、お電話にてご連絡ください。