Tier Exception Request Form

To submit request electronically, please go to providerportal.surescripts.net/ProviderPortal/login **OR** covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: <u>888-446-8535</u>

Mail: Blue Cross NC, ATTN: Part D Coverage Determination

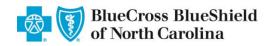
P.O. Box 2251, Durham, NC 27702-2251

Call: 888-298-7552 Blue Medicare Rx

888-296-9790 Blue Medicare HMO/PPO

			ay Delay Processing		
Prescrib	er Informa	ntion	Patient Information		
Physician Name:		NPI #:	Patient Name:		
Office Contact Person:			Patient ID #:		
Office Phone #: Office Fa		: #:	Home Phone #:		
Address:			Sex: □ Female □ Male		
City: State: Zip:			DOB:		
	ſ	Diagnosis and Med	dication Information		
Medication Requested:			Diagnosis Code:		
Strength and Route of Administration:			Dosing Schedule:		
Quantity per 30 days:					
		Please answer	questions below		
 alternatives. Tier exceptions for biolo Tier exceptions for gene Tier exception requests (e.g., levothyroxine table 	egical produceric medication cannot be cets).	ets will be approved to ons will be approved onsidered for medica onsidered for medica	oved to the lowest tier which contains brand nate the lowest tier which contains biological alternation to the lowest tier which contains generic alternations that do not have an alternative available attions that have been approved as a formulary	natives. atives. on a low	
Check the "Yes" box to believes that waiting for ability to regain maximumours for a coverage determined. 2. Please indicate if the requirements.	request an e r a decision u um function i ermination. puested med	expedited review if the under the standard tin n serious jeopardy. A ication is a:	enrollee or his/her physician or other prescribe ne frame may place the enrollee's life, health, or standard review will have a decision made within 72	r	□ No
A. If YES, please ans i. Please provide ii. Is the patient cu 30 mg, request	king the requester the follower the follower the treatment trently taking is for 60 mg	owing: nt start date of the regard a lower dose of the large.	quested medication://_ e requested medication (e.g., currently taking		
product was brand-name intolerance, FDA labeled	e, generic, or I contraindic	⁻ over-the-counter), o ation, or hypersensiti	eviously tried and failed (please specify if the r to which the patient has a documented vity to related to this diagnosis. (Please include on).		
		PLEASE CONTIN	UE TO NEXT PAGE		

Updated: 01/01/2024



5. Is the requested medication a high-risk medication (please refer to the patient's formulary)? ☐ Yes A. If YES , please answer the following:	□ No					
i. Is the patient <i>at least</i> 65 years of age?□ Yes	□ No					
ii. Do the benefits of the requested high-risk medication outweigh the risks for this patient? ☐ Yes iii. Has the prescriber documented that the potential side effects and risks of this high-risk						
medication have been discussed with the patient or authorized representative of the patient? □ Yes	□ No					
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:						