

## NONFORMULARY EXCEPTION REQUEST or VALUE PRIOR AUTHORIZATION

## PRIOR REVIEW/CERTIFICATION FAXBACK FORM

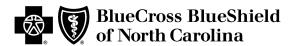
**INCOMPLETE FORMS MAY DELAY PROCESSING** 

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

PRESC	CRIBER NAME	PRESCRIBER		ue Cross NC PROV ID # / TA		e]
CONTACT PERSON		PRESCR	PRESCRIBER PHONE		PRESCRIBER FAX	
PRESC	CRIBER ADDRESS	CITY	STATE	ZIP		
PATIEI	NT NAME	Blue Cross	NC ID	DATE OF BIRTH	GENDER M F	
PLEA	SE ANSWER THE FO	LLOWING QUESTIO	NS:	Diagnosis Cod	e:	
Drug	Name:		Strength:			
Dosa	ge Form:		Quantity Rec	quested:	_ Per:	
1.	Has the patient taker	n the requested medic	ation in the past 180	days?	Yes	□ No
2.	If YES, please answ a. Is the patient	dication being used to  yer the following que stable on the requeste s condition too critical	stions and submit ed medication?	medical record doc	□ Yes umentation: □ Yes	□ No □ No □ No
3.		ontraceptive medication provider requesting the based on a determination	ne non-preferred ver	sion of the prescribed	I	□ No
4.	Please provide indica	ation for the requested	I medication:			
5.	. Is the requested medication and/or dose considered medically necessary and appropriate for treating the condition?□ Yes					□ No
6.	Is the requested med	dication treating a chro	onic, disabling, or life	-threatening disease	?□ Yes	□ No
7.	equivalent?a. If YES, has the	dication a BRAND med ne patient tried the ger te answer the followi e patient have a life-th	neric product of the r	requested medication	□ Yes ?□ Yes	□ No □ No
	medic ii. Did th	al intervention that is in the prescriber complete ting form?	not anticipated with t and submit an FDA	the brand product? MedWatch Adverse	□ Yes Event	□ No
	If YES	6, please provide a course on page 2, please of	opy of the complete	ed MedWatch form.		L INO

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## NONFORMULARY EXCEPTION REQUEST or VALUE PRIOR AUTHORIZATION (continued)

8.	Has the patient tried and failed any other medications for this diagnosis?  ☐ Yes  If YES, please answer the following questions:	□ No						
	<ul> <li>a. Were the previously tried alternative medications detrimental to the patient's health or ineffective in the treatment of the disease or condition?</li></ul>	□ No						
	medications be detrimental to the patient's health or ineffective in treating the disease or condition again?□ Yes	□ No						
9.	Please provide previously tried and failed medications for this diagnosis ( <i>omission</i> of information indicates N/A or none):							
10.	Please list any medications the member has a contraindication or is intolerant to for this diagnosis (omission of information indicates N/A or none):	S						
11.	Is the requested medication a non-standard formulation (e.g. chew, concentrate, elixir, film, granule, liquid, orally disintegrating tablet (ODT), powder, sprinkle, suspension, syrup)? \(\text{Yes}\)	 □ No						
	If YES, please answer the following questions:	□No						
	<ul><li>a. Is the patient 11 years of age or younger?</li><li>b. Is the patient unable to take solid dosage forms?</li></ul>	□ No						
	c. Is the patient taking any other medications in a solid dosage form?	□No						
	d. Is the patient using an enteral feeding tube? Yes	□ No						
	<ul> <li>i. If YES, can the tablet/capsule formulation be crushed or opened for administration?□ Yes</li> </ul>	□ No						
12.	Please provide a clinical rationale for the requested medication and address alternatives that hav	e not						
	been tried, but may be clinically inappropriate; may include medical record documentation, labora results, and/or other supporting medical documentation ( <i>omission of information indicates N/A or</i>	•						
	se certify the following by signing and dating below:	0)						
	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 C	Cross NC may request medical records for this patient at any time in order to verify this information. I							
	r understand that if Blue Cross NC determines this information is not reflected in my patient's medical ds, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies ble.							
	criber's Signature (Required): Date:							

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

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