BlueCross BlueShield of North Carolina

Use for Blue Medicare Rx Standard and Blue Medicare Rx Enhanced Plans

TIER EXCEPTION REQUEST FORM

(Incomplete form may delay processing)

Prescriber Information		Patient Information	
Physician Name:	NPI #:	Patient Name:	
Office Contact Person:		Patient ID # :	
Office Phone # :	Office Fax # :	Home Phone # :	
Address:		Sex (circle): M F	DOB:
City: State: Zip:			

FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

1. **Medication Requested** (name, strength, dosage form): _____
2. **Diagnosis** this medication is used for: _____
3. Is this medication a **new prescription** for the patient? □ YES □ NO
4. **List drugs that are on a lower BCBSNC formulary tier that this patient has tried for their condition, including the formulary generic equivalent, if pertinent. CLINICAL INFORMATION IS REQUIRED** about past effectiveness or side effects of the formulary alternative(s) for this patient._____

_____

_____

_____

OR

5. **If, in your opinion, the alternative formulary drugs on a lower tier would not be as effective in treating the member's condition and/or would cause the member to have adverse effects**, please supply clinical rationale for expected differences in efficacy and/or adverse effects between therapeutically similar alternative products. ***(CLINICAL INFORMATION IS REQUIRED if this pertains to your patient.)***_____

_____

_____

_____

Note: the following must be met for approval:

- Member must have tried and failed *at least one* formulary drug *that is covered on a lower tier* than the requested drug.
- Tier exception requests are only permitted from Tier 4 to Tier 3, or from Tier 2 to Tier 1, (*see Evidence of Coverage*).
- Please provide an explanation if alternative formulary drugs on a lower tier would *not* be as effective in treating the member's condition and/or would cause the member to have adverse effects.

I certify that, to the best of my knowledge, the above information is accurate.

Physician Signature:_____ Date: _____

PLEASE NOTE: *A request received without supporting clinical information may be denied.*

Please Return Completed Form to: Fax number: 1-888-446-8440 **|** Provider Line Telephone: 1-888-298-7552
Address: Blue Medicare Rx. Attn: Part D Coverage Determinations
P.O. Box 17509, Winston-Salem, NC 27116-7509

12/2014