

NONFORMULARY EXCEPTION REQUEST or MEDICAL NECESSITY 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

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 ANSWER THE FOLLOWING QUESTIONS:

Diagnosis Code: _____

Drug Name: _____ **Strength:** _____

Dosage Form: _____ **Quantity Requested:** _____ **Per:** _____

1. Has the patient taken the requested medication in the past 180 days?..... Yes No
2. Is the requested medication being used to treat a seizure related or refractory psychiatric disorder?..... Yes No
If YES, please answer the following questions and submit medical record documentation:
 - a. Is the patient stable on the requested medication?..... Yes No
 - b. Is the patient's condition too critical to try other medications?..... Yes No
3. Is the request for a contraceptive medication / device?..... Yes No
 - a. **If YES**, is the provider requesting the non-preferred version of the prescribed contraceptive based on a determination of medical necessity?..... Yes No
4. Please provide indication for the requested medication: _____
5. Is the requested medication and/or dose considered medically necessary and appropriate for treating the condition?..... Yes No
6. Is the requested medication treating a chronic, disabling, or life-threatening disease?..... Yes No
7. Is the requested medication a BRAND medication with an FDA approved AB rated generic equivalent?..... Yes No
 - a. **If YES**, has the patient tried the generic product of the requested medication?..... Yes No
If YES, please answer the following questions:
 - i. Did the patient have a life-threatening side effect to the generic that required medical intervention that is not anticipated with the brand product?..... Yes No
 - ii. Did the prescriber complete and submit an FDA MedWatch Adverse Event Reporting form?..... Yes No

If YES, please provide a copy of the completed MedWatch form.

****Please note: continued on page 2, please complete and sign page 2 for prior authorization request****

**NONFORMULARY EXCEPTION REQUEST or
MEDICAL NECESSITY PRIOR AUTHORIZATION (*continued*)**

8. Has the patient tried and failed any other medications for this diagnosis?..... Yes No

If YES, please answer the following questions:

- a. Were the previously tried alternative medications detrimental to the patient's health or ineffective in the treatment of the disease or condition?..... Yes No
- b. In the prescribing provider's opinion, would the previously tried alternative 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 (*omission 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*):

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)?... Yes No

If YES, please answer the following questions:

- a. Is the patient 11 years of age or younger?..... Yes No
- b. Is the patient unable to take solid dosage forms?..... Yes No
- c. Is the patient taking any other medications in a solid dosage form?..... Yes No
- d. Is the patient using an enteral feeding tube?..... Yes No
 - i. **If YES**, can the tablet/capsule formulation be crushed or opened for administration?..... Yes No

12. Please provide a clinical rationale for the requested medication and address alternatives that have not been tried, but may be clinically inappropriate; may include medical record documentation, laboratory results, and/or other supporting medical documentation (*omission of information indicates N/A or none*):

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