



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

- Medication Requested** (name, strength, dosage form): _____
- Diagnosis** this medication is used for: _____
- Is this medication a **new prescription** for the patient? YES NO
- 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

- 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: 1-888-446-8535 | Provider Line Telephone: 1-888-296-9790
Address: Blue Medicare HMO/PPO. Attn: Part D Coverage Determinations
P.O. Box 17509, Winston-Salem, NC 27116-7509

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