BlueCross BlueShield of North Carolina

NON-FORMULARY EXCEPTION AND PHARMACY PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

Please answer the following questions:

Dx Code:_____________

1. Where will the patient obtain the medication?:
   ☐ Doctor's office ☐ Outpatient facility ☐ Pharmacy/Specialty Pharmacy ☐ Other:_______________
2. **PLEASE PRINT** Medication Requested:
   Name: ______________________________ Strength: ____________ Dosage Form: _____________
3. Is the patient currently taking this drug? ....☐Yes ☐No
   a. If Yes, Please provide the start date of drug:____
4. **PLEASE PRINT** documentation of previous drug(s) tried for patient's diagnosis (including strength), duration of trial, and reason for failure on the lines below:
   ____
   ____
   ____
5. **PLEASE PRINT** clinical rationale for requested drug below (**Attach** any medical record documentation of laboratory results or other supporting medical documentation):
   ____
   ____
   ____
   ____
   ____
   ____

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 BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required):____________________________________Date:________________

For BCBSNC members, fax form to 1-800-795-9403

Last Revision Date: 10/2012