MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Medicare Part D Coverage Determination Request Form

Blue Cross Blue Shield of Massachusetts Clinical Pharmacy Department

25 Technology Place Hingham, MA 02043

Telephone: (800) 366-7778 or Fax to Clinical Pharmacy Program: (866) 463-7700

Patient Information		**Prescriber Information**	
Patient name:		Prescriber name:	
Member ID#:		NPI # :	
Address:		Address:	
Home Phone:	DOB:	Office Phone #:	Office Fax #:

Diagnosis and Medical Information			
Medication (name and strength):	Route of Administration:	Directions for use:	Quantity Requested:
Patient's Diagnosis or ICD-9-CM code:	Expected Length of Therapy:	☐ New Prescription OR Date Therapy Initiated:	
Prescriber's Signature:		Date:	

Type of Coverage Determination Requested:

☐ **Exception Request** (Formulary Exception request for non-formulary drug, Quality Care Dosing override for drug with quality care dosing limit, Step therapy medication)

☐ **Prior Authorization Request**

☐ **Exception to Prior Authorization Request** (requesting individual consideration for member who does not meet Medical Policy criteria and requires coverage outside Medical Policy guidelines)

☐ **Tiering Exception Request** (*Note: not all medications are eligible for tiering exception)

Rationale for Exception Request or Prior Authorization FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, or therapeutic failure)

☐ **Specify below**: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change

☐ **Specify below**: Anticipated significant adverse clinical outcome

☐ Medical need for different dosage form and/or higher dosage

☐ **Specify below:** (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

☐ Request for formulary tier exception

☐ **Specify below**: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

Other:_____ ☐ Explain below

REQUIRED EXPLANATION:

_____

_____

_____

_____

Request for Expedited Review

☐ REQUEST FOR EXPEDITED REVIEW [24 HOURS]

BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THEMEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.