blue california

Medicare Part D Prescription Coverage Request Form – *TIER EXCEPTION*
View our formulary online at https://www.blueshieldca.com/medformulary2023
Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information
Important Note: Expedited Decisions *If the standard decision time of 72 hours or less may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, an expedited (fast) decision can be requested.* ☐ CHECK THIS BOX IF A DECISION NEEDS TO BE GIVEN WITHIN 24 HOURS.
Date of Request:

Physician Information	Patient Information
Physician's Name: ☐ PCP; ☐ Specialty:_____ Office contact:_____ _____ Phone#: ( ) Facsimile #: ( )	Patient's Name: Patient's Address: Blue Shield ID#: Birthdate: Patient's height/weight: Drug Allergies:

DRUG(S) REQUESTED:	QUANTITY:	EXPECTED LENGTH OF THERAPY:
STRENGTH:	DIRECTIONS:	

DIAGNOSIS: Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes. (If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)	ICD-10 CODE(S):

FAX form to: 1 (888) 697-8122	Pharmacy Services Phone #: 1 (800) 535-9481

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OTHER RELEVANT DIAGNOSES	ICD-10 CODE:

PATIENT CLINICAL INFORMATION

1. Is this new therapy? ☐ Yes ☐ No. If no, please provide date therapy was started.

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)

DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	DATES of Drug Trials	RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)

TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

Prescriber's Rationale for request:

Specify below if not noted in the DRUG HISTORY section earlier on the form: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum

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dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]

Required Explanation

_____

_____

_____

_____

_____

Prescriber Signature:	Date:

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