

BCN Advantage HMO-POSSM



**Blue Care
Network
of Michigan**

Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Attn:

Blue Care Network Clinical Pharmacy Help Desk

Date: _____

Mail Code C303
20500 Civic Center Drive
Southfield, MI 48076
Phone: 1-800-437-3803
Fax: 1-800-459-8027

This form **cannot** be used to request: Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

BLUE CARE NETWORK- BCN Advantage HMO-POSSM			
Patient Information		Physician Information	
Name		Name	
Member ID#		NPI/DEA#	
Address		Address	
City		City	
State	Zip Code	State	Zip Code
Home Phone		Office Phone	
Sex	Male Female	Fax	
DOB		Contact Person	

Diagnosis and Medical Information			
Medication			
Strength and Route of Administration			Frequency
New Prescription <input type="checkbox"/>	Date Therapy Initiated ^A	Expected Length of Therapy	
Quantity	Height	Weight	Drug Allergies
Prescriber's Signature			Date

A health plan with a Medicare contract.



**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 (e.g.: 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 high dosage.

Specify below: (1) Dosage form(s) and/or dosages 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 (4) I want to pay a lower copayment because another drug is same category but lower copayment or my drug was in a lower tier and it was moved to a higher tier and I want the lower copayment.

I request prior authorization for the drug my doctor has prescribed.

I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my doctor prescribed (formulary exception).

My drug plan charged me a higher copayment for a drug than it should have.

I want to be reimbursed for a covered prescription that I paid for out-of-pocket.

Other (explain below):

Note: If you are asking for a formulary tiering exception, your PRESCRIBING PHYSICIAN must provide a statement to support your request. You cannot ask for a tiering exception for a drug in the plan's Specialty Tier. In addition, you cannot obtain a brand-name drug at the copayment that applies to generic drugs.

REQUIRED EXPLANATION:

Signature: _____

Date: _____

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 TIMEFRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.

Information on this form, including the fax number you provide, is protected health information and subject to all privacy and security regulations under HIPAA.