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Medicare and more
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Medicare Part D Coverage Determination Request Form

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).

Plan Name: BLUE CARE NETWORK – BCN Advantage					
Patient Information			Prescriber Information		
Patient Name:			Prescriber Name:		
Member ID#			DEA#		
Address:			Address:		
City:		State	City:		State:
Home Phone:		Zip:	Office Phone#	Office Fax*:	Zip:
Sex (circle): M F	DOB:		Contact Person:		
Diagnosis and Medical Information					
Medication:		Strength and Route of Administration		Frequency:	
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:		Expected Length of Therapy:		Qty:	
Height/Weight:		Drug Allergies:	Diagnosis:		
Prescriber's Signature (required):				Date:	
Rationale for Exception Request or Prior Authorization FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION					
<input type="checkbox"/> Alternate drug(s) contraindicated or previously tried, but with adverse outcome (i.e., 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);					
<input type="checkbox"/> 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					
<input type="checkbox"/> 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					
<input type="checkbox"/> 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					
<input type="checkbox"/> Other: _____ Explain below					
REQUIRED EXPLANATION: _____ _____ _____					
Request for Expedited Review					
<input type="checkbox"/> 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 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					