Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Request for External Review (Exception for Non-Covered Drug)

Do not use this form if your External Review Request is not for a drug exception request.

You may be eligible for an External Review at no cost to you if ALL of the following apply:

- Your coverage is through an individual or underwritten small group policy or certificate.
- You made a request to receive a drug not covered under your plan and you were denied.
- Your request for external review is within 4 months of receipt of the denial.
- The patient is covered under the plan.

You are responsible for submitting:

- A copy of the denial of your exception request.
- Pertinent documentation, such as medical records, statements from doctors, research material that supports your position, etc.

Note: It is your responsibility to submit medical records
Always send copies. Never send original documents.

1. Patient Name | Name of INSURED Person

BCBSM Policy (Contract) Number | Group Number

Date the request for the drug was made or denial was received

Name of prescribing physician and telephone number

2. Statement of request:
a. Provide a brief explanation of the problem and the resolution you are seeking.
b. Include a statement from your physician that all covered formulary drugs on any tier will be or have been ineffective, would not be as effective as the non-formulary drug or would have adverse effects.

4. This request is being filed by (choose one)

- ■ The patient – provide patient's contact information in Part 5
- ■ The patient's parent (if patient is a minor child); or the patient's legal guardian – provide parent or legal guardian's contact information in Part 5
- ■ A representative authorized by the patient – provide authorized representative's contact information in Part 5

5. Contact information for person filling this form

Name of Patient, Parent, Legal Guardian or Authorized Representative

Address

City | State | Zip

Daytime phone number | Evening phone number

If you are not the patient, what is your relationship to the patient?

If person filling is NOT the patient or the patient's parent or the patient's legal guardian, the patient must designate the representative by reading and signing the statement in Part 6 below:

6. Patient authorization statement
I authorize the person named in Part 5 to act as my authorized representative in this External Review.

Signature of Patient | Date

7. Authorization to review medical information

I authorize the Independent Review Organization and any other health care provider needed to review protected health information and records pertaining to this external review.

Signature of Patient | Date

8. Send your Request for External Review to:
Appeals and Grievance Unit – Pharmacy External Review
Blue Care Network
PO Box 284
Southfield, MI 48037
Fax: 866-522-7345

3. Urgent External Review Requirements (If you are not requesting an urgent external review, or your request does not meet the conditions below, skip to Part 4.)

The following conditions must be met:

- You're going through a treatment that isn't listed on the pharmacy drug list.
- Your health condition could be life threatening or you may lose the ability to regain full bodily function.
- The timeframe of 72 hours would seriously jeopordize your life or health.
- The request is filed within 10 days of receipt of the denial of your exception request.

My request meets these requirements. By completing items (3a.) and (3b.), I am requesting an Urgent External Review.

(3a.) Date you requested an urgent exception request _____

(3b.) Name and phone number of substantiating physician _____

Telephone number only to request Urgent External Review: 800-662-6667. To qualify conditions in Section 3 must be met.

05/17/19