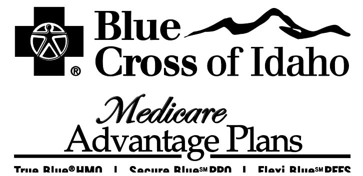
PRESCRIPTION DRUG EXCEPTION REQUEST



Please complete the entire form and fax or mail to:
Wellpoint Pharmacy Management
P.O. Box 9083
Oxnard, CA 93021-9083
Fax: 1-800-204-0028

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, erectile dysfunction drugs, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations). If you believe your prescription is in one of these classifications, please call your physician to discuss options.

Patient Information	***Physician Information***
Patient Name:	Name:
Enrollee ID#:	Specialty:
Date of Birth:	DEA#:
Patient Telephone #:	Telephone Number:
Address:	Physician Fax#:

Medication	Strength	Dosage	Quantity per 30 Days

Type of Prescription Exception Request

_____ I need a drug that is not on the plan's list of covered drugs (formulary exception).
Please check all that apply.

___ I have previously taken two formulary products in the same classification without result.

___ For maintenance medications, I have taken a formulary product for six months or more.

___ I have documented adverse effects with formulary medications.

H1350 H1302 H5862 MS 082028 (08/07)

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

______ I request an exception for the plan's quantity limit so that I can get the quantity prescribed by my doctor.

______ My drug plan charges a higher co-payment for the prescribed drug than it charges for another drug that treats my condition. I am requesting to pay the lower amount. *Note: If you are asking for a formulary or tiering exception, your Prescribing Physician must provide a statement to support your request. You cannot request a tiering (copayment) exception for a drug in the Specialty Tier. In addition, you cannot obtain a brand name drug at the copayment amount that applies to generic drugs.*

Attach any supporting documents or information that we should consider.

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health, or ability to regain maximum function, you can ask for an expedited (faster) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a faster decision.

______ I need an expedited (fast) coverage determination (attach physician's supporting statement, if applicable.)

_________________________________ _________________________________

Beneficiary/ Requestor's Signature Date

If you have questions, or need assistance with this form, please call Blue Cross of Idaho's Medicare Advantage customer Service at 1-800-289-8617 or 208-331-7687 or TTY 1-800- 337-1363. Customer Services is available from 8:00 a.m. through 8:00 p.m. MST, every day.