BlueCross BlueShield Federal Employee Program

Primary Breast Cancer Prevention Coverage Member Request Form

Send completed form to:
Service Benefit Plan
Attn: Reconsideration
P.O. Box 52080
Phoenix, AZ 85072-2080
FAX: 1-877-378-4727

CARDHOLDER COMPLETES

Date: ____ / ____ / _____

Patient Name: _____ / _____ / _____
First MI Last

Patient Address: _____
Street Address

_____
City / State / Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ☐ F ☐ R _____
Cardholder Identification Number

If approved, your $0 prevention benefit override will be applied to the generic for the benefit year. Approval reauthorization is required for each benefit year.

PHYSICIAN COMPLETES

_____ _____ _____
Physician Name (Print Clearly) Specialty Physician NPI #

Physician Address: _____
Street Address

_____ (_____)_____ (_____)_____
City / State / Zip Office Phone Office Fax

NOTE: Drug selection and prescribing physician signature must be completed to process this request:

1. **Please select drug requested**:

   ❑ **tamoxifen** ❑ **raloxifene** ❑ **exemestane** ❑ **anastrozole** ❑ **letrozole**

2. **I attest, as prescribing physician, to ALL of the following:**

   a. This member is a female member **age 35 years of age or older**

   b. The requested medication is being used for **primary breast cancer prevention**

   c. This member is at **increased risk for developing breast cancer** (risk factors for breast cancer include increasing age, family history of breast or ovarian cancer (especially among first-degree relatives and onset before age 50 years), history of atypical hyperplasia or other nonmalignant high-risk breast lesions, previous breast biopsy, and extremely dense breast tissue)

   d. This member has ***not*** been diagnosed with either breast cancer, ductal carcinoma in situ (DCIS), or lobular carcinoma in situ (LCIS) in the past

   e. This member does ***not*** have a history of thromboembolic events (deep venous thrombosis, pulmonary embolus, stroke, or transient ischemic attack)

   _____ ____ /____ /____
   Physician Signature Date

Prescriber Certification: I certify that I am the physician and all information provided on this form to be true and correct to the best of my knowledge and belief.