BlueCross BlueShield
Federal Employee Program

HIGH CHOLESTEROL
Managed/Excluded Formulary Exception
Member Request Form

Send completed form to:
Service Benefit Plan
Prior Approval
Attn: Clinical Services
P.O. Box 52080 MC139
Phoenix, AZ 85072-2080
Fax: 1-877-378-4727

Please have the prescribing physician complete the physician portion and questions and then submit this completed form.

Member Information (required)

Cardholder Name:		Date:	
Member Name:		Date of Birth:	Sex: Male Female
Street Address:		Cardholder ID: **R**	
City:	State: Zip:	Is the member enrolled in STANDARD option or BASIC option? ❑STANDARD Option ❑BASIC Option	

Prescriber Information (required)

Provider Name:	Specialty:	NPI:	
Office Phone:	Office Fax:		
Office Street Address:	City:	State:	Zip:
Physician Signature:			

Covered Medications**

amlodipine-atorvastatin	**atorvastatin**	**fluvastatin**	**lovastatin**
pravastatin	**rosuvastatin**	**simvastatin**	

**For a full list of covered medications, visit www.FEPblue.org for the formulary information.

PHYSICIAN ONLY COMPLETES

All fields below must be completed to begin processing the Managed/Excluded Formulary Exception Request. The Managed/Excluded Formulary Exception program for all non-covered medications listed below except Nikita, Zypitamag and Flolipid is for Basic Option Members only. The Managed/Excluded Formulary Exception program for Nikita*, Zypitamag* and Flolipid* is for Basic Option and Standard Option.

Which Non-Covered Medication is being requested:

❒ **ADVICOR**	❒ **ALTOPREV**	❒ **CADUET**	❒ **CRESTOR**	❒ **LESCOL/XL**	❒ **FLOLIPID***
❒ **LIPITOR**	❒ **LIPTRUZET**	❒ **LIVALO**	❒ **MEVACOR**	❒ **PRAVACHOL**	
❒ **SIMCOR**	❒ **VYTORIN**	❒ **ZOCOR**	❒ **NIKITA***	❒ **ZYPITAMAG***	

Has the patient experienced a failure of, an intolerance to, a contraindication to, or an adverse reaction to **TWO** or more of the covered options (amlodipine-atorvastatin, atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, and simvastatin)? ❒Yes* ❒No

IF YES, please indicate which of the following was experienced by the patient on the covered option:
❒TREATMENT FAILURE ❒INTOLERANCE ❒ADVERSE REACTION ❒CONTRAINDICATION

1) Indicate ALL the covered option drug names the patient has tried and unable to take:

❒ amlodipine-atorvastatin ❒ atorvastatin ❒ fluvastatin ❒ lovastatin
❒ pravastatin ❒ rosuvastatin ❒ simvastatin

❒ Other (specify): _____

2) What is the reason that the patient cannot take a covered medication?

_____

Please remember to sign the signature line above. We cannot process without a physician's signature. Thank you

Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. High Cholesterol Managed/Excluded Formulary Exception Request Form Revised 9/13/17