BlueCross BlueShield Federal Employee Program.

Tier Exception 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

Member Information (required)

Patient Name:		Date:	Weight (Pediatric Patients ONLY): ☐kg ☐lbs
Street Address:		Date of Birth:	Sex: ☐Male ☐Female
City:	State: Zip:	Cardholder ID: R	

Current Member Benefit Plan:
☐ **FEP Blue Standard™** ☐ **FEP Blue Basic™**

Prescriber Information (required)

Prescriber Name:		Specialty:	
Office Phone:	Office Fax:	NPI:	
Office Street Address:	City:	State:	Zip:

Prescriber Signature: _____ *(Must be Handwritten by **Prescriber**)*

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.

PLEASE NOTE: If approved, claims processed prior to approval date will not be adjusted or covered under the benefit.

PHYSICIAN ONLY COMPLETES

All fields below must be completed to begin processing the Tier Exception request.

Brand Drug Name copay request for (please specify drug name): _____

Patient's Diagnosis: _____

Please specify Dosing Directions: _____

Indicate the outcome that best describes your patient's experience with all drugs in this therapeutic class:

☐ **Therapeutic Failure(s)** (90 day course) of covered generic and/or brand medications in this therapeutic class.

Drug Name	Indicate if Brand or Generic	Describe the therapeutic failure(s):
	☐ Brand ☐ Generic	
	☐ Brand ☐ Generic	
	☐ Brand ☐ Generic	

☐ **Adverse Event(s)** with covered generic and/or brand medications in this therapeutic class.

Drug Name	Indicate if Brand or Generic	Describe the adverse event(s):
	☐ Brand ☐ Generic	
	☐ Brand ☐ Generic	
	☐ Brand ☐ Generic	

☐ **Other Reason(s)** that would lead the patient not to use covered generic and/or brand medications in this therapeutic class: _____

_____

If a member chooses to change plans during the benefit year exception approvals may no longer be valid. Please consult your plan brochure for formulary coverage.

Approved requests for medications which are subject to prior authorization require additional criteria to be met prior to final validation and coverage determination. Approval will be given once all required documentation has been received.

Prior authorization forms may be found at: https://www.caremark.com/wps/portal/WEBSUPPORT_FAQS?cms=CMS-PWCM-2034779