

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):			
Street Address:			Date of Birth:			Se	Sex:			
			Date of Birth.				 □Mal	е	□Fem	ale
City:	State: Z	ip:	Cardholder ID:	R		1 1	1 1	ı	1	
Current Member Benefit Plan:										
STANDARD Option BASIC Option										
Prescriber Information (required)										
Prescriber Name:	Specialty:									
Office Phone: Office Fax:							NPI:			
Office Street Address:			City:	ity:			State: Zip:			
Prescriber Signature: /Must be Handwritten by Prescriber)										
(Widst be Handwillen by Frescriber)									•	
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	s) with covered	d generic a	ind/or brand n	nedic	cations in	this the	erapeutic cla	iss.		
Drug Name Indicate if Brand or C			eneric Describe the therapeution				ıre(s):			
	☐ Brand	☐ Ger	neric							
	☐ Brand	☐ Ger								
	☐ Brand	☐ Ger	neric							
☐ Adverse Event(s) with	n covered gene	eric and/or	brand medicat	ions	in this the	rapeutio	c class.			
Drug Name	Indicate if	Indicate if Brand or Generic Describe the adverse					s):			
	☐ Brand	☐ Ger	neric							
	☐ Brand	☐ Ger	neric							
	☐ Brand	☐ Ger	neric							
☐ 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 chan	ao plono durina t	ha hanafit ya	ar execution on	rovol	n may na la	agor box	valid Dlagge a	opoult	vour plan	

hooses 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

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