COVERAGE EXCEPTION
PHYSICIAN FAX FORM

ONLY the prescriber or clinic personnel may complete this form. This form is for prospective, concurrent, and retrospective reviews

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross Blue Shield of North Dakota web site at *www.bcbsnd.com*.

PATIENT INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

INSURANCE INFORMATION

BCBS ID Number:	Group Number:

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

1. Is the patient currently treated with the requested medication? ..... ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Please list all reasons for selecting the requested **medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions.) _____
3. Please list all other medications the patient is **currently taking for treatment of this diagnosis.** _____
4. Please list any other medications the patient has **previously tried and failed for treatment of this diagnosis**. (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.)

_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____

Please fax or mail this form to:
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Eagan, Minnesota 55121

TOLL FREE

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