BlueCross BlueShield Federal Employee Program

Formulary 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

CARDHOLDER OR PHYSICIAN COMPLETES

If you are requesting a copay exception for more than one medication, please use a separate form for each medication.

Date: ____ / ____ / _____

Patient Name: _____ / _____ / _____
First MI Last

Patient Address _____ _____ _____ _____
Street Address City State Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M_____ F _____ **R** [ ] Cardholder Identification Number

PHYSICIAN ONLY COMPLETES

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

Patient's Diagnosis: _____

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

Please specify Dosing Directions: _____

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

❒ **Therapeutic Failure(s)** with generic and/or brand medications in this therapeutic class.
1) Indicate ALL the drug name(s) the patient has failed on in this class: _____

_____

2) Describe the therapeutic failure(s): _____

_____

❒ **Adverse Event(s)** with generic and/or brand medications in this therapeutic class.
1) Indicate ALL the drug name(s) the patient has had an adverse event within this class: _____

_____

2) Describe the adverse event(s): _____

_____

_____ (_____) _____ (_____) _____
Physician Name (Print Clearly) Phone Fax

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____ / _____ / _____
Prescriber's NPI Physician Signature Date

P**rescriber 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.