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

PLEASE NOTE: If approved, claims processed prior to approval date will not be adjusted as the copay on previous fills was correct based on the plan benefit.

PHYSICIAN ONLY COMPLETES

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

Patient's Diagnosis: _____

Brand Drug Name 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

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.

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