BlueCross BlueShield Federal Employee Program

Standard – Basic – FEP Blue Focus Formulary 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:
☐**STANDARD** Option ☐**BASIC** Option ☐**FEP Blue Focus** Option

Prescriber Information (required)

Provider Name:		Specialty: Neurology		
Office Phone: (215) 957-9254	Office Fax: (215) 957-9254	**NPI**:		
Office Street Address: 1151 Old York Rd, Ste 200		City: Abington	State: 19001	Zip: 19001

Physician Signature: _____

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.

PHYSICIAN ONLY COMPLETES

All fields below must be completed to begin processing this request.

Drug request for (please specify drug name): _____

Patient's Diagnosis: _____

Indicate any clinical reason(s) this medication is required for this patient: _____

_____

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

☐ **Therapeutic Failure(s)** with 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	
	☐ 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	
	☐ Brand ☐ Generic	

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

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. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with Blue Cross and Blue Shield. Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.