BlueCross BlueShield of Illinois

FOR INTERNAL USE ONLY

Coverage Exception Request Form – Medical Benefit Therapeutic Alternatives

This form is only to be used for a coverage exception request for a non-covered drug included on the Medical Benefit Therapeutic Alternatives Summary. All Medical Benefit Therapeutic Alternative medications have an associated Blue Cross and Blue Shield of Illinois medical policy. These drugs may also be subject to medical necessity review. You will receive written notification once a determination has been made. For additional information contact customer service or visit **bcbsil.com/find-care/medical-rx.**

Fax each completed Coverage Exception Request Form to 800-852-1360.

If unable to fax, you may mail your request to BCBSIL, PO Box 660603, Dallas, TX, 75266-0603.

URGENT – Definition is below, and if not met the request will be re-classified from urgent to standard priority.

- Waiting could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or;
- Waiting could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological function, or;
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

☐ STANDARD ☐ URGENT	TODAY'S DATE	SCHEDULED/ANTICIPATED SERVICE/ADMISSION DATE

PROVIDER DATA

SUBMITTER INFORMATION

SUBMITTING PROVIDER	TELEPHONE NUMBER
CONTACT FIRST NAME	CONTACT LAST NAME

ORDERING PHYSICIAN

ORDERING PHYSICIAN: (INDIVIDUAL – TYPE 1 NPI) (MUST BE 10 DIGITS)	
ORDERING PHYSICIAN FIRST NAME	ORDERING PHYSICIAN LAST NAME
RENDERING PHYSICIAN PROVIDER SPECIALTY	
CONTACT FIRST NAME	CONTACT LAST NAME
TELEPHONE NUMBER	FAX NUMBER
STREET ADDRESS	

CITY	STATE	ZIP

RENDERING PROVIDER/FACILITY

RENDERING FACILITY/PHYSICIAN/PROVIDER: (ORGANIZATION–TYPE 2 NPI) (MUST BE 10 DIGITS)	
RENDERING PROVIDER/FACILITY NAME	TAX ID
CONTACT FIRST NAME	CONTACT LAST NAME
TELEPHONE NUMBER	FAX NUMBER
STREET ADDRESS	

CITY	STATE	ZIP

MEMBER DATA

MEMBER IDENTIFICATION NUMBER: (INCLUDE THE 3-DIGIT PREFIX)	
GROUP NUMBER	PATIENT'S DATE OF BIRTH
MEMBER'S FIRST NAME	MEMBER'S LAST NAME
PATIENT'S FIRST NAME	PATIENT'S LAST NAME

DOCUMENTATION: ATTACH ANY DOCUMENTATION THAT SUPPORTS OR FACILITATES YOUR REVIEW.
THE FOLLOWING INFORMATION IS REQUIRED FOR REVIEW. CHECK ALL THAT APPLY.

PLACE OF TREATMENT

☐ PROVIDER OFFICE ☐ OUTPATIENT FACILITY ☐ INPATIENT FACILITY ☐ HOME ☐ OTHER

☐ EVALUATION/HEALTH HISTORY ☐ OFFICE/THERAPY NOTES	DIAGNOSIS CODES

NON-COVERED DRUG NAME(S)

DOSE/FREQUENCY/DURATION

FOR CONTINUATION REQUESTS (SUBMIT RESPONSE FOR QUESTIONS 1-3):

1. Is the patient currently treated with the requested non-covered drug for a covered indication (including new members)? ..... Yes ☐ No ☐
2. Is the patient experiencing benefit from the non-covered drug as evidenced by disease stability or improvement? ..... Yes ☐ No ☐
3. Is the dosing in accordance with an authoritative source? ..... Yes ☐ No ☐

Please note: medical records including chart notes are required for documenting current therapy and patient status.

FOR INITIAL THERAPY REQUESTS (SUBMIT RESPONSE FOR QUESTIONS 4-6):

4. Please list all covered medical benefit therapeutic alternatives previously tried for treatment of this diagnosis, if applicable.

	DATE(S)		DATE(S)
	DATE(S)		DATE(S)
	DATE(S)		DATE(S)

5. Please list all reasons for selecting the requested non-covered drug over covered alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose tried, information supporting dose over FDA max).

Please note: medical records including chart notes are required for documenting that the available medical benefit therapeutic alternatives are contraindicated, likely to be less effective, or cause an adverse reaction or other harm for the patient that's not expected to occur with the requested agent.

6. Is the covered drug(s) experiencing documented drug shortages or recalls from a wholesaler, manufacturer, the ASHP (American Hospital of Health-System Pharmacist) Drug Shortage web page or the US Food and Drug Administration? ..... Yes ☐ No ☐

FOR REQUESTS FOR ENZYME REPLACEMENT THERAPY FOR TYPE 1 GAUCHER DISEASE:

Is the request for Cerezyme (imiglucerase) for a patient that is ≥ 2 years of age and < 4 years of age? ..... Yes ☐ No ☐

This form does not apply to government programs (Illinois Medicaid and Medicare Advantage), Federal Employee Programs or any of our commercial HMO members.