



**BlueCross
BlueShield
of Kansas**

An Independent Licensee of the
Blue Cross and Blue Shield Association.

Drug Coverage Exception Criteria - For Individuals Who Purchased BlueCare/KS Solutions Products

These criteria will apply to the Health Insurance Marketplace for Groups using BlueCareSM Formulary

Coverage Exception Criteria

These criteria apply to any request for medication that is not included on Essential Health Benefit covered drug list and can be used to treat a medical condition/disease state that is not otherwise excluded from coverage under the pharmacy benefit.

CRITERIA FOR APPROVAL

The requested agent will be approved when the following are met:

1. The requested agent is used to treat a medical condition/disease state that is not otherwise excluded from coverage under the pharmacy benefit
AND
2. The requested agent meets existing Utilization Management Criteria for use if applicable
AND
3. The patient's diagnosis is an FDA-approved or CMS-approved compendia accepted indication
AND
4. ONE of the following:
 - a. The patient has tried and failed two formulary alternatives (if applicable) for the diagnosis being treated with the requested drug
OR
 - b. The prescriber has provided documentation stating that available formulary alternatives are contraindicated, likely to be less effective, or cause an adverse reaction or other harm for the patient, or the prescriber states that the patient is currently receiving the requested medication and is at risk if s/he changes therapy

Length of Approval: 12 months



**COVERAGE EXCEPTION
Physician Fax Form**

BCBS Kansas REQUIRES that this form be completed by the prescriber. This form is for prospective, concurrent and retrospective reviews.

The following documentation is **REQUIRED** for prior authorization. Incomplete forms will be returned for additional information. To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com For formulary information, please visit the Blue Cross and Blue Shield of Kansas website at <http://www.bcbsks.com>

PATIENT INFORMATION

Today's Date:

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

INSURANCE INFORMATION

ID Number:	Group Number:
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested medication started? _____	
2. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): _____ _____ _____	
3. Please list all other medications the patient is currently taking for treatment of this diagnosis. _____ _____ _____	
4. Please list all 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: _____	

<p>Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 1305 Corporate Center Drive Eagan, Minnesota 55121 TOLL FREE Fax: 877.480.8130 Phone: 866.469.5660</p>	<p>CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 866.469.5660, and return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p>
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