BlueCross BlueShield of Kansas
An Independent Licensee of the Blue Cross and Blue Shield Association.

Drug Coverage Exception Criteria - For Individuals Who Purchased on the Health Insurance Marketplace

These criteria will apply to the Health Insurance Marketplace for Groups using BlueCare℠ 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 patient's diagnosis is an FDA-approved or CMS-approved compendia accepted indication
   AND
3. 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

AND

4. The requested agent meets existing Utilization Management Criteria for use if applicable

Length of Approval: 12 months

COVERAGE EXCEPTION
Physician Fax Form

BlueCross BlueShield of Kansas

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:

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? ..... ☐ Yes ☐ 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: _____

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**

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