blue CALIFORNIA

Medicare Part D Prescription Coverage Request Form – *FORMULARY EXCEPTION*
View our formulary online at **<blueshieldca.com/medformulary2026>**
Notice: We only accept coverage requests from the prescriber, the prescriber's office staff, the member, and the member's authorized representative. We do not accept requests from pharmacies or third party vendors unless a valid representative form has been submitted. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.
Important Note: Expedited Decisions *If the standard decision time of 72 hours or less may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, an expedited (fast) decision can be requested.* ☐ CHECK THIS BOX IF A DECISION NEEDS TO BE GIVEN WITHIN 24 HOURS.
Date of Request:

Physician Information	**Patient Information**
Physician's Name: ☐ PCP; ☐ Specialty:_____ Office contact:_____ Phone#: ( ) Facsimile #: ( ) Address:	Patient's Name: Patient's Address: Blue Shield ID#: Birthdate: Patient's height/weight: Drug Allergies:

DRUG(S) REQUESTED:	QUANTITY:	EXPECTED LENGTH OF THERAPY:
STRENGTH:	DIRECTIONS:	
DIAGNOSIS: Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes.		ICD-10 CODE(S):

FAX form to: 1 (888) 697-8122	**Pharmacy Services Phone #: 1 (800) 535-9481**

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H2819_25_113C_PHA_C 09112025
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A53824_0925

(If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)	
OTHER RELEVANT DIAGNOSES:	ICD-10 CODE:

PATIENT CLINICAL INFORMATION

Type of exception requested *(please check the appropriate box)*

☐ Request for a drug that is not on the plan's list of covered drugs.

☐ Request for continuation of a drug that was on the plan's list of covered drugs before, but has been or will be removed during the plan year (formulary exception)

☐ Request an exception to the requirement that another drug is tried before receiving the drug prescribed.

☐ Request an exception to the plan's limit on the number of pills (quantity limit) that can be received at one time.

1. Is this new therapy? ☐ Yes ☐ No. If no, please provide date therapy was started.

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)

DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	**DATES of Drug Trials**	**RESULTS of previous drug trials** **FAILURE vs INTOLERANCE (explain)**

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2. What is the current drug regimen for the condition?

_____

_____

_____

DRUG SAFETY

3. Any **FDA NOTED CONTRAINDICATIONS** to the requested drug? ☐ YES ☐ NO

4. Any concern for a **DRUG INTERACTION** with the addition of the requested drug to the enrollee's current drug regimen? ☐ YES ☐ NO

If the answer to either of the questions noted above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety

_____

_____

_____

HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY

5. If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient? ☐ YES ☐ NO

OPIOIDS – (please complete the following questions if the requested drug is an opioid)

6. What is the daily cumulative Morphine Equivalent Dose **(MED)**? **mg/day**

7. Are you aware of other opioid prescribers for this enrollee? ☐ YES ☐ NO
If so, please explain.

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8. Is the stated daily MED dose noted medically necessary? ☐ YES ☐ NO

9. Would a lower total daily MED dose be insufficient to control the enrollee's pain? ☐ YES ☐ NO

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

Prescriber's Rationale for request:

☐ **Alternate drug(s) previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** [Specify below if not already noted in the DRUG HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed]

☐ **Alternative drug(s) contraindicated, would not be as effective or likely to cause adverse outcome.** A specific explanation why alternative drug(s) would not be as effective or anticipated significant adverse clinical outcome and why this outcome would be expected is required. If contraindication(s), list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** A specific **explanation** of any anticipated significant adverse clinical outcome and why a significant adverse outcome would be expected **is required** – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.

☐ **Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]

☐ **Other** (explain below)

Required Explanation

_____

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_____ _____ _____ _____	
Prescriber Signature:	**Date:**

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