



Medicare Part D Prescription Coverage Request Form

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: <input type="checkbox"/> PCP <input type="checkbox"/> Specialty: _____ Office contact: _____ Phone#: () Facsimile #: () Address:	Patient's Name: Patient's Address: Blue Shield ID#: Birthdate: Patient's height/weight: Drug Allergies:	
DRUG REQUESTED:	QUANTITY:	EXPECTED LENGTH OF THERAPY:
STRENGTH AND ROUTE OF ADMINISTRATION:	DIRECTIONS:	

FAX form to: 1 (888) 697-8122

Pharmacy Services Phone #: 1 (800) 535-9481

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<p>DIAGNOSIS: Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes. (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)</p>	ICD-10 CODE(S):
<p>OTHER RELEVANT DIAGNOSES:</p>	ICD-10 CODE(S):
<p align="center">PATIENT CLINICAL INFORMATION</p>	
<p>Type of coverage determination requested <i>(please check the appropriate box)</i></p> <p><input type="checkbox"/> Prior Authorization</p> <p><input type="checkbox"/> Request for a drug that is not on the plan's list of covered drugs (formulary exception)</p> <p><input type="checkbox"/> 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)</p> <p><input type="checkbox"/> Request an exception to the requirement that another drug is tried before receiving the drug prescribed (formulary exception).</p> <p><input type="checkbox"/> Request an exception to the plan's limit on the number of pills (quantity limit) that can be received at one time (formulary exception).</p> <p><input type="checkbox"/> Request an exception to the plan's prior authorization rules that must be met before I get a prescribed drug (formulary exception).</p> <p><input type="checkbox"/> Request to lower the copayment for a drug that has been prescribed (tiering exception).</p> <p>1. Is this new therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide date therapy was started</p> <p>2. Check the box that best describes the location where the drug will be administered:</p> <p><input type="checkbox"/> Patient's home or assisted living facilities</p> <p><input type="checkbox"/> Long Term Care Facilities (LTC)/Skilled Nursing Facilities (SNF)</p>	

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- ☐ Ambulatory Infusion Center (infusion center supplies the drug)
- ☐ Ambulatory Infusion Center (retail/outpatient pharmacy supplies the drug)
- ☐ Office administered (office supplies the drug)
- ☐ Office administered (retail/outpatient pharmacy supplies the drug)
- ☐ Other (explain): _____

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)

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

DRUG SAFETY

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

5. 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

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HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY	
6. 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
OPIOIDS – (please complete the following questions if the requested drug is an opioid)	
7. What is the daily cumulative Morphine Equivalent Dose (MED)?	mg/day
8. Are you aware of other opioid prescribers for this enrollee? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, please explain.	
9. Is the stated daily MED dose noted medically necessary? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10. Would a lower total daily MED dose be insufficient to control the enrollee's pain? <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> 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] <input type="checkbox"/> 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 <input type="checkbox"/> Patient would suffer adverse effects if he or she were required to satisfy the prior authorization requirement. A specific explanation of any anticipated significant adverse clinical outcome and why this outcome would be expected is required. <input type="checkbox"/> 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	

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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]

☐ **Request for formulary tier exception** Specify below if not noted in the DRUG HISTORY section earlier on the form: (1) formulary or preferred 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/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]

☐ **Other** (explain below)

Required Explanation

Provider Signature:

Date:

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