



# Pharmaceutical Exception Request

Please consult your physician to complete this form. Incomplete or incorrect information may delay response.

Indicate the type of exception request with an  next to one of the following:  Non-Covered Drug only  Waive Copay for Brand Name Contraceptive  
**Request for Expedited Review (24 Hours)**  By placing a check mark here, I certify that the standard review time (72 hrs) may seriously jeopardize the life or health of the member or member's ability to regain maximum function.

<b>DATE:</b>	<b>DRUG REQUESTED (ONE DRUG PER REQUEST):</b>	<b>QUANTITY PRESCRIBED:</b>	
<b>MEMBER</b>		<b>PRESCRIBING PRACTITIONER</b>	
Name:	Member ID No:	DOB:	Name: Office Fax No:                      Office Phone No: Signature:
Medical condition for drug requested: Expected duration of drug treatment: Practitioner's reason for copay waiver of brand name contraceptive :			
<b>MEDICATION HISTORY</b>			
Please list any previous or current drugs related to the medical condition, including drug names and treatment dates. Current drugs are defined as drugs used by the member within the last 30 days. For previously prescribed drugs, include beginning and ending dates of treatment. If none or not applicable to diagnosis, check <input type="checkbox"/> N/A			
<b>DRUG NAME</b>			<b>DATES AND DURATION OF TREATMENT</b>
	<input type="checkbox"/> CURRENT	<input type="checkbox"/> PREVIOUS	
	<input type="checkbox"/> CURRENT	<input type="checkbox"/> PREVIOUS	
	<input type="checkbox"/> CURRENT	<input type="checkbox"/> PREVIOUS	
	<input type="checkbox"/> CURRENT	<input type="checkbox"/> PREVIOUS	

**COMPLETE THIS FORM AND SUBMIT BY ONE OF THE FOLLOWING:**

**Fax:** PHARMACY MANAGEMENT DEPARTMENT: 1-888-343-4232 **Email:** fax\_Pharmacy\_Management@bcbst.com, place Pharmaceutical Exception Request in the subject line  
**For requests by phone:** Members may call the Member Service number on the back of your BlueCross identification card. Providers may call Provider Service at **1-800-924-7141**