BlueCross BlueShield of North Carolina

ACA COPAY WAIVER

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]	
CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX	
PRESCRIBER ADDRESS	CITY	STATE	ZIP
PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER

Select medications are available with no cost sharing for members. These drugs and more information can be found at http://www.BlueCrossNC.com/preventive. If a member cannot use these medications for medical reasons, a copay waiver can be requested for another drug with this form.

This form is NOT a request for a FORMULARY EXCEPTION of a drug that is not covered on the member's formulary.

Please answer the following questions: **Diagnosis Code: _____**

1. Is the request for brand name Soltamox (tamoxifen) oral solution?.....☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Is the patient utilizing the requested medication for primary prevention of breast cancer because the patient is high risk? .....☐ Yes ☐ No
   b. Does the patient have a prior diagnosis of breast cancer?.....☐ Yes ☐ No
   c. Does the patient have difficulty swallowing or cannot swallow generic tamoxifen tablets?...☐ Yes ☐ No
   d. Does the patient have a documented intolerance or hypersensitivity to generic tamoxifen tablets?.....☐ Yes ☐ No

2. Is the request for Femara (letrozole)?.....☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Is the patient utilizing the requested medication for primary prevention of breast cancer because the patient is high risk?.....☐ Yes ☐ No
   b. Does the patient have a prior diagnosis of breast cancer?.....☐ Yes ☐ No
   c. Is the patient clinically able to utilize the medications available at $0 cost share (anastrozole, tamoxifen, raloxifene)? .....☐ Yes ☐ No

3. Is the request for Apretude?.....☐ Yes ☐ No
   IF YES, please answer the following question:
   a. Is the patient utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV?.....☐ Yes ☐ No

4. Is the request for Viread?..... ☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Is the patient utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV?.....☐ Yes ☐ No
   b. Is the member clinically unable to use emtricitabine-tenofovir 200-300mg tablets (generic Truvada)?.....☐ Yes ☐ No

****NOTE: continued on page 2; please sign page 3 to request copay waiver****

BlueCross BlueShield of North Carolina

ACA COPAY WAIVER (*continued*)

5. Is the request for Descovy?..... ☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Is the patient utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV?..... ☐ Yes ☐ No
      If YES, please submit medical record documentation.
   b. Is the member clinically unable to use emtricitabine-tenofovir 200-300mg tablets (generic Truvada)?..... ☐ Yes ☐ No
      If YES, please submit medical record documentation.

6. Is the request for brand name Truvada?..... ☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Is the patient utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV?..... ☐ Yes ☐ No
      If YES, please submit medical record documentation.
   b. Has the patient tried the generic version of the requested medication (generic Truvada)?.. ☐ Yes ☐ No
      i. **If YES,** did the patient have a sub-therapeutic or intolerant response to an inactive ingredient of the generic product that is not present in the brand?..... ☐ Yes ☐ No
   c. Does the patient have a documented intolerance to an inactive ingredient of the generic product that is not found in the brand?..... ☐ Yes ☐ No

7. Is the request for emtricitabine-tenofovir (generic Truvada)?..... ☐ Yes ☐ No
   IF YES, please answer the following question:
   a. Is the patient utilizing the requested medication for pre-exposure prophylaxis (PrEP) for the prevention of HIV?..... ☐ Yes ☐ No

8. Is the request for one of the following statins: atorvastatin, fluvastatin, fluvastatin ER, lovastatin ER, pitavastatin, rosuvastatin, simvastatin?..... ☐ Yes ☐ No
   If YES, please select the requested medication and answer the following questions:
   ☐ Atorvastatin 10-80mg per day
   ☐ Fluvastatin 20-80mg per day
   ☐ Fluvastatin ER 80mg per day
   ☐ Lovastatin ER 20-40mg per day
   ☐ Pitavastatin 1-4mg per day
   ☐ Rosuvastatin 5-40mg per day
   ☐ Simvastatin 10-40mg per day
   a. Is the requested statin covered under the pharmacy benefit or has been previously approved by Blue Cross NC?..... ☐ Yes ☐ No
   b. Is the patient clinically unable to utilize the medications available at $0 cost share (pravastatin or lovastatin)?..... ☐ Yes ☐ No
   c. Is the patient 40-75 years of age?..... ☐ Yes ☐ No
   e. Does the patient have any of the following risk factors?
      i. Dyslipidemia..... ☐ Yes ☐ No
      ii. Diabetes..... ☐ Yes ☐ No
      iii. Hypertension..... ☐ Yes ☐ No
      iv. Smoking..... ☐ Yes ☐ No
   f. Does the patient have a calculated 10-year risk of a cardiovascular event of 10% or greater per the American College of Cardiology and American Heart Association's Atherosclerotic Cardiovascular Disease (ASCVD) calculator?..... ☐ Yes ☐ No

****NOTE: continued on page 3; please sign page 3 to request copay waiver****

BlueCross BlueShield of North Carolina

ACA COPAY WAIVER (*continued)*

9. Is the request for a contraceptive medication / device?.....☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Please list the requested contraceptive medication / device: _____
   b. Is the requested medication/device covered under the pharmacy benefit or has it been previously approved by BlueCross NC?.....☐ Yes ☐ No
   c. Is the provider requesting the non-preferred version of the prescribed contraceptive based on a determination of medical necessity?.....☐ Yes ☐ No

10. Is the request for a bowel preparation medication?.....☐ Yes ☐ No
    IF YES, please answer the following questions:
    a. Please list the requested bowel preparation medication: _____
    b. Is the requested medication covered under the pharmacy benefit or has it been previously approved by Blue Cross NC?.....☐ Yes ☐ No
    c. Is the patient clinically unable to utilize the medications available at $0 cost share?.....☐ Yes ☐ No

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-800-795-9403