BlueCross BlueShield of North Carolina

High Dollar Verification - NC Standard

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

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
			M F

PLEASE ANSWER THE FOLLOWING QUESTIONS: **Diagnosis Code:** _____

Drug Name: _____ **Strength:** _____

Dosage Form: _____ **Quantity Requested:**_____ **Per:** _____

1. Please provide indication for the requested medication: _____
2. Does the patient have an FDA-approved (or compendia supported) indicated for the requested medication?.....☐ Yes ☐ No
3. Can the prescribed dose be achieved using a lesser quantity of a higher strength?.....☐ Yes ☐ No
4. Is the requested dose within the maximum FDA labeled dose, or the safest studied dose per the manufacturer's product insert?.....☐ Yes ☐ No
   If NO, please submit medical record documentation in support of therapy with a higher dose for the intended diagnosis.
5. Please provide previously tried and failed medications for this diagnosis (*omission of information indicates N/A or none*):
   _____
   _____
6. Please list any medications the member has a contraindication or is intolerant to for this diagnosis (*omission of information indicates N/A or none*):
   _____
   _____

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