CREDENCE

NON-COVERED PROVIDER ADMINISTERED DRUG EXCEPTION AUTHORIZATION REQUEST FORM

*This form is for authorization of provider administered drug benefits for non-covered drugs **ONLY** and must be **COMPLETELY** filled out.*

GENERAL INFORMATION

☐ Request for Non-Covered Drug Exception

Patient Name

Patient's Home Address

City | State | Zip

Date of Birth (mm/dd/yyyy) ___/___/____

Contract Number (include prefix)

PRESCRIBER INFORMATION

Prescriber Name

Practice Address

City | State | Zip

Office Phone | Office Fax

Practice Type
☐ PCP
☐ Specialty: _____

National Provider Identifier (NPI)

REQUEST TYPE

(Please check one) ☐ **Initial Authorization** ☐ **Authorization Renewal** (Please attach any additional medical information.)

TREATMENT INFORMATION

Drug/Strength/Frequency/Quantity Requested:

Duration of Disease (Years):

Place of Services:

Route of Administration:

Healthcare Professional to Administer:
☐ Yes ☐ No

ICD-10 Codes:

Medical rationale for use (include chart notes if possible):

List medications this patient has tried for this condition (include current medications and titration history if applicable)

Drug	Strength/Frequency	Dates of Therapy	Outcome of Therapy
1.			
2.			
3.			
4.			
5.			

Does this patient have any co-morbid conditions that will affect therapy: ☐ Yes ☐ No
If so, please list: _____

Note: Medications received through manufacturer coupons or samples are not accepted as justification of prior therapy.

Prescriber Signature

(Required for processing request)

I certify this information is complete and correct to the best of my knowledge.

Prescriber Signature | Date

Please attach any additional medical justification.

SUBMISSION INSTRUCTIONS

EMAIL You may email the signed and completed form to Pharmacy Review at:
Pharm-Pol-Rvw-Comm@bcbsal.org

MAIL *You may mail the signed and completed form to:*
Pharmacy Review
450 Riverchase Parkway East • Birmingham, AL 35244