Independence Blue Cross

Non-Formulary Exception Request

****ONLY COMPLETED REQUESTS WILL BE REVIEWED****

Date: _____

Drug requested: _____ *(one drug per form only)*

Quantity: _____ *(quantity edit only)*

Patient name: _____

Prescribing physician: _____

Patient ID #: _____

Provider NPI: _____

Patient DOB: _____

Office contact: _____

Office fax #: _____

Office phone #: _____

1. **Provider specialty** *(specify all)* _____

2. **Diagnosis for drug requested** *(specify all)* _____

3. **Medication history** *(Please list any previous or current therapy related to the diagnosis below using drug names and dates.)*

☐ **N/A** *(If none or not applicable to diagnosis, check N/A.)*

Drug name	Date	Duration

Please add any other supporting medical information that may be useful in the decision-making process:

_____

_____

_____

_____

Please fax your completed form to 1-888-671-5285. Your office will receive a response via fax or mail.

For internal use only

Coverage effective date: ____ /____ /_____

Document #: _____ Rx coverage: Y N **Approved**

Processor initials: _____ Prior auth: Y N STANDARD – SELECT **Reviewer initials:** _____

Date: _____ Sex: M F LOB: _____ **Date approved:** _____

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