CareFirst BlueCross BlueShield
Medicare Advantage
10455 Mill Run Circle
Owings Mills, MD 21117-5559
carefirst.com/medicare

CareFirst Medicare Advantage

Fax completed form to: 855-633-7673
Questions, please call: 888-970-0917
24 hours a day 7 days a week

Important Information about Prescription Drug Coverage

To: From:

Fax: Pages:

Re: Request for a Lower Copay (Tiering Exception): Please Respond.

- Please complete the attached Request for a Lower Copay* (Tiering Exception Form).
- To prevent delays in the review process please complete all requested fields.
- Completed forms should be faxed to: 855-633-7673 It is not necessary to fax this cover page.

Information about this Request for a Lower Copay (Tiering Exception)

Use this form to request coverage of a brand or generic in a higher cost sharing tier at a lower cost sharing tier. Certain restrictions apply.

To process this request, documentation that all of drugs to treat the same medical condition on the lower cost sharing tier would not be as effective or would have adverse effects must be provided. Please provide clinical information or other evidence to support the medical necessity of the drug on the higher cost sharing tier, including previous drugs attempted for this patient's condition. Please note: **Tiering exceptions cannot be requested for non-formulary drugs approved under the formulary exception process, drugs in the specialty tier, or brand-name drugs at the price of a generic drug.**

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

* Copay, copayment or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Member privacy is important to us. Our employees are trained regarding the appropriate way to handle our members' private health information.

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Request for a Lower Copay (Tiering Exception)

☐ Request Expedited Review

Patient Information

Name: _____
Member ID: |__|__|__|__|__|__|__|__|__|__|__|
Medicare ID: |__|__|__|__|__|__|__|__|__|__|__|
Date of Birth: ____/____/____ Sex: M / F (Circle One)
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____
Nursing Home Resident? YES / NO (Circle One)
Home Care Patient? YES / NO (Circle One)

Prescriber and Pharmacy Information

Name: _____
Specialty: _____
DEA: |__|__|__|__|__|__|__|__|__|
NPI: |__|__|__|__|__|__|__|__|__|__|
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____ Fax: _____
Pharmacy Name: _____
NCPDP: |__|__|__|__|__|__|__|
NPI: |__|__|__|__|__|__|__|__|__|__|
Phone: _____ Fax: _____

All items below this line are for Physician Use Only

Information for Requested Drug

Drug Name: _____ Drug Requested: Brand / Generic (Circle One)
Strength: _____ Dosage: _____ 30 Day Qty.____ Drug: Newly Prescribed / Refill (Circle One)
Directions: _____ Diagnosis: _____

ICD-10 Code: _____ Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review time frame will seriously jeopardize the health of your patient. To request an expedited review, simply indicate at the top of this page.

Request for a Lower Copay (Tiering Exception) Criteria

Medical Justification: Please provide medical justification for requesting a lower copay (tiering exception) for a brand or generic drug in a higher cost-sharing tier. Please address why all formulary alternatives on any lower tier of the formulary for treatment of the same condition would not be effective or would cause adverse effects. List previous drugs and doses attempted for this patient, condition and dates or approximate dates or duration of treatment (if known). Document adverse effects requiring discontinuation and/or reason for perceived ineffectiveness. Attach additional pages if necessary.

☐ If all lower-tier agents would not be effective, please specify prior treatment failures.

_____
_____
_____

☐ If all lower-tier agents would have adverse effects, please specify prior adverse effect history.

_____
_____
_____

☐ If patient preference for higher-tier drug, please provide your clinical rationale.

_____
_____
_____

☐ If no available lower-tier alternatives have been previously tried, please check this box.

I attest that the information provided on this form is true and accurate as of this date.

Prescriber's Signature _____ **Date:** _____