Specialty Pharmacy Program Exception Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

INSTRUCTIONS:

Complete entire form and fax it to:
Anthem Blue Cross Customer Service
1-818-234-4141

Request Date

SECTION 1: PATIENT INFORMATION

Last name		First name		M.I.
Date of birth	Contact phone no.	ID no.		
Address		City	State	Zip code
Date of diagnosis	Primary diagnosis	ICD-10 Code(s)		Current weight

SECTION 2: PHYSICIAN INFORMATION

Last name	First name	M.I.	DEA or NPI no.	
Tax ID no.	Address	City	State	ZIP code
Phone no.	Fax no.	Office contact name	Physician specialty	

SECTION 3: MEDICATION OR PRESCRIPTION INFORMATION

Drug name		Strength / Dose		
Direction for use (SIG)				
Date medication needed	Service from date	Service thru date	HCPCS or CPT code(s)	Number of refills

Place of Service
☐ Physician office ☐ Patient home ☐ Other (please specify): _____

SECTION 4: EXCEPTION REQUEST

If you believe that the patient should not be required to get the medication through the Specialty Pharmacy Program for any of the following reasons, please attach ALL supporting documentation, lab results, progress notes, etc., if applicable.

1. Due to medical necessity, the specialty medication must be obtained and administered immediately, within the next 24 hours. ☐ Yes ☐ No
2. The patient is enrolled in a financial assistance program that is subsidizing all or part of the cost. ☐ Yes ☐ No
3. Other (please provide explanation and documentation) _____ ☐ Yes ☐ No

_____

_____

_____

SECTION 5: PRESCRIBER SIGNATURE

Prescriber signature	Prescriber name	Date

Prior authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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