



**Independence  
Blue Cross**

## Cost Share Exception Request

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

**Drug Requested** \_\_\_\_\_  
(one drug per form only)

**Quantity** \_\_\_\_\_  
(qty. edit only)

**Date:** \_\_\_\_\_

**Patient ID#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Provider NPI:** \_\_\_\_\_

**Prescribing Physician:** \_\_\_\_\_

**Office Contact:** \_\_\_\_\_

**Office Fax #:** \_\_\_\_\_

**Office Phone:** \_\_\_\_\_

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

**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, using drug names and dates)

**N/A** If none or not applicable to diagnosis, indicate "N/A."

<b>Drug Name</b>	<b>Date</b>	<b>Duration</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAX: (888) 671-5285 or EMAIL: [FSS\\_Standard\\_Medicare@catalystrx.com](mailto:FSS_Standard_Medicare@catalystrx.com)**  
**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**