



**BlueCross BlueShield
of South Carolina**

An Independent Licensee of the Blue Cross
and Blue Shield Association



**PDP Copayment Exception Request
(Tiering Exception)**

Patient's Name: _____

Drug Plan ID Number: _____

Type of Exception Request

Standard

Emergency

Copayment Exception – Requested Drug and Dose _____

Please check and complete all that apply:

As noted below, this patient has experienced documented failure after trying the following formulary medications that are within the same therapeutic class as the requested drug.

1. _____ 2. _____

Check either or both statements below that may be applicable to this patient.

This patient has a documented allergic or adverse reaction to at least one of these formulary agents.

Based on my knowledge of this patient's medical condition, all other drugs on any tier of the formulary for treatment of the same condition would not be as effective as the requested drug, would have adverse effects, or both.

Required Prescribing Physician Attestation

My signature indicates that the above information is true and can be substantiated by information contained in this patient's medical records.

Print Name: _____ Date: _____

Signature: _____ Phone Number: _____

Fax completed form to (803) 264-9581