PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this prior authorization form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review

☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. What is the patient's weight? _____ (kg)
2. Is the patient currently being treated with the requested agent? ..... ☐ Yes ☐ No
   If yes, is the patient stable on the requested agent? ..... ☐ Yes ☐ No
   Are they at risk if therapy is changed? ..... ☐ Yes ☐ No
3. Is the request for an FDA-approved agent for diabetes mellitus? ..... ☐ Yes ☐ No
   If yes, has the prescriber stated that it is medically inappropriate for the patient to use a formulary alternative? ..... ☐ Yes ☐ No
4. Is the patient taking another medication in the same therapeutic class for treatment of the same indication? ☐ Yes ☐ No
   If yes, will the other medication be discontinued before starting the requested medication? ..... ☐ Yes ☐ No
5. Please list all reasons for selecting the requested medication, dosing schedule and quantity over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried). _____
   _____
   _____
6. Please list other medications the patient will use in combination with the requested medication for treatment of this diagnosis.
   _____
   _____
7. Please list all medications the patient has previously tried and failed for treatment of this diagnosis**.** (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.)

   _____ Date(s): _____ _____ Date(s):_____
   _____ Date(s): _____ _____ Date(s):_____
   _____ Date(s): _____ _____ Date(s):_____

*****MEDICAL RECORDS INCLUDING CHART NOTES ARE REQUIRED FOR THIS REQUEST*****

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For Atopic Dermatitis:

8. Please indicate where the patient will be using the requested medication. Check any that apply:

☐ Face (including eyelids) ☐ Neck

☐ Skin folds (e.g. groin, armpit/under arm) ☐ Other (please describe): _____

For Acute Migraine 5HT agents:

9. Has the patient been evaluated for and does not have medication overuse headache? ..... ☐ Yes ☐ No

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**

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