AFFORDABLE CARE ACT (ACA)
COPAY WAIVER 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 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. Is the patient currently treated with the requested agent? ☐ Yes ☐ No

For aspirin requests:

2. Is the requested aspirin agent medically necessary? ☐ Yes ☐ No
3. Is the patient pregnant, at high risk of preeclampsia, and using the requested agent after 12 weeks of gestation? ☐ Yes ☐ No

For bowel prep requests:

4. Is the requested bowel prep agent medically necessary? ☐ Yes ☐ No
5. Will the requested agent be used for the preparation of colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy? ☐ Yes ☐ No

For breast cancer prevention requests:

6. Is the requested breast cancer primary prevention agent medically necessary? ☐ Yes ☐ No
7. Is the agent requested for the primary prevention of breast cancer? ☐ Yes ☐ No

For contraceptive requests:

8. Is the requested contraceptive agent medically necessary? ☐ Yes ☐ No
9. Is the requested agent being prescribed for contraception? ☐ Yes ☐ No

For fluoride supplementation requests:

10. Is the requested fluoride supplement medically necessary? ☐ Yes ☐ No

For folic acid requests:

11. Is the requested folic acid supplement medically necessary? ☐ Yes ☐ No
12. Is the requested folic acid supplement to be used in support of pregnancy? ☐ Yes ☐ No

Please continue to the next page.

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

For HIV infection: pre-exposure prophylaxis (PrEP) requests:

13. Is the requested PrEP agent medically necessary? ☐ Yes ☐ No
14. Is the patient at high risk of HIV infection? ☐ Yes ☐ No
15. Has the patient recently tested negative for HIV? ☐ Yes ☐ No

For infant eye ointment requests:

16. Is the requested infant eye ointment medically necessary? ☐ Yes ☐ No
17. Is the requested agent requested for the prevention of gonococcal ophthalmia neonatorum? ☐ Yes ☐ No

For iron supplement requests:

18. Is the requested iron supplement medically necessary? ☐ Yes ☐ No
19. Is the patient at increased risk for iron deficiency anemia? ☐ Yes ☐ No

For statin requests:

20. Is the requested statin medically necessary? ☐ Yes ☐ No
21. Is the requested agent for use in ONE of the following low to moderate daily statin regimen (with up to the highest dosage strength as noted): 1) Atorvastatin 10-20 mg per day (20 mg tablet), 2) Fluvastatin 20-80 mg per day (40 mg capsule), 3) Fluvastatin ER 80 mg per day (80 mg tablet), 4) Lovastatin 20-40 mg per day (40 mg tablet), 5) Lovastatin ER 20-40 mg per day (40 mg tablet), 6) Pitavastatin 1-4 mg per day (4 mg tablet), 7) Pravastatin 10-80 mg per day (80 mg tablet), 8) Rosuvastatin 5-10 mg per day (10 mg tablet), or 9) Simvastatin 10-40 mg per day (40 mg tablet, 40mg/5mL suspension)? ☐ Yes ☐ No
22. Does the patient have at least one of the following risk factors: 1) dyslipidemia, 2) diabetes, 3) hypertension, or 4) smoking? ☐ Yes ☐ No
23. Does the patient have a calculated 10-year risk of a cardiovascular event of 10% or greater per the American College of Cardiology and American Heart Association's Atherosclerotic Cardiovascular Disease (ASCVD) calculator? ☐ Yes ☐ No

For tobacco cessation:

24. Is the patient a non-pregnant adult? ☐ Yes ☐ No
25. Is the requested tobacco cessation agent medically necessary? ☐ Yes ☐ No

For vaccines:

26. Is the requested vaccine medically necessary? ☐ Yes ☐ No
27. Will the requested vaccine be used per the recommendations of the Advisory Committee on Immunization Practices/CDC? ☐ Yes ☐ No

Please fax or mail this form to:
Prime Therapeutics LLC
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Eagan, MN 55121

TOLL FREE

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