COVERAGE EXCEPTION
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
2. Does the patient have any FDA labeled contraindications to the requested agent? ..... ☐ Yes ☐ No
3. Which state will the patient be receiving treatment in? _____
4. Is the requested agent being used off-label for treatment of a tick-borne disease? ..... ☐ Yes ☐ No
5. Is the requested agent being used for treatment to eliminate or provide maximum feasible treatment including to prevent functional impairment related to vision function, oral function, inflammation, bleeding, infections and other medical complications associated with nevus flammeus (a.k.a port-wine stains)? ..... ☐ Yes ☐ No
6. Can the prescribed dose be achieved with a lower quantity of a higher strength that does not exceed the limit? ..... ☐ Yes ☐ No
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. **Please note: medical records including chart notes are required for documenting previous therapy failures.**

   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
8. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose tried, information supporting dose over FDA max). **Please note: medical records including chart notes are required for documenting that the available alternatives (formulary/non-formulary/OTC) are contraindicated, likely to be less effective, or cause an adverse reaction or other harm for the patient that's not expected to occur with the requested agent.** _____
   _____
   _____

For requests for brand name agents with generic equivalents:

9. Has the prescriber completed and submitted an FDA MedWatch Adverse Event Reporting form on behalf of this patient? ..... ☐ Yes ☐ No

   If yes, **a copy of the completed and submitted FDA MedWatch Adverse Event Reporting form is required.**

Please continue to the next page.

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

10. Is the request for a biologic agent? ☐ Yes ☐ No
    If yes, has the patient started treatment with the requested biologic agent on the medical benefit and is transitioning to maintenance on the pharmacy benefit? ☐ Yes ☐ No

For opioid dependence, alcohol dependence, or tobacco cessation agent requests:

11. For BCBSIL members, is the request for a court-ordered opioid dependence, alcohol dependence, or tobacco cessation agent? ☐ Yes ☐ No

For oncology agent requests:

12. Has the patient been diagnosed with stage 4 advanced metastatic cancer? ☐ Yes ☐ No
    If yes, is the use of the requested agent consistent with best practices for the treatment of stage 4 advanced metastatic cancer and is supported by peer reviewed medical literature? ☐ Yes ☐ No
13. Does the patient have an FDA labeled limitation of use for the requested agent that is not supported by National Comprehensive Cancer Network (NCCN)? ☐ Yes ☐ No

For opioid agent requests:

14. Has a formal, consultative evaluation which includes BOTH of the following been conducted: 1) diagnosis, and 2) a complete medical history which includes previous and current pharmacological and non-pharmacological therapy? **Please note, chart notes are required.** ☐ Yes ☐ No
15. Is the patient undergoing treatment of chronic non-cancer pain? ☐ Yes ☐ No
    If yes, has a formal, consultative evaluation, which includes the need for continued opioid therapy being assessed, been conducted? **Please note, chart notes are required.** ☐ Yes ☐ No
    If yes, has the prescriber reviewed the member's controlled substance records in the state's prescription drug monitoring program (PDMP)? ☐ Yes ☐ No
    If yes, is the patient routinely (at least every 3 months) being assessed for function, pain status and opioid dose? ☐ Yes ☐ No
    If yes, is the patient concurrently using a benzodiazepine? ☐ Yes ☐ No
    If yes, please provide support for the use of opioids with a benzodiazepine: _____
    _____

For fertility preservation, use this chart and answer the following questions for non-preferred agent requests:

Preferred Agents	Non-preferred Agents
Ganirelix Acetate	Cetrotide
Menopur (menotropins)	Gonal-F/ Rediject (follitropin)
Follistim AQ (follitropin)	Crinone (progesterone)
Endometrin (progesterone)	Novarel (chorionic gonadotropin)
Ovidrel (choriogonadotropin alfa)	Chorionic gonadotropin
Pregnyl (chorionic gonadotropin)	

16. Has the patient tried and had an inadequate response to a preferred agent? ☐ Yes ☐ No
17. Does the patient have an intolerance or hypersensitivity to a preferred agent? ☐ Yes ☐ No
18. Does the patient have an FDA labeled contraindication to a preferred agent? ☐ Yes ☐ No

For gender identity disorder (GID), gender dysphoria, of gender incongruence requests:

19. When was treatment initiated? _____
20. Has the provider documented that immediately terminating the use of the treatment would cause harm to the patient? ☐ Yes ☐ No
21. Has the provider instituted a period of time where treatment is systematically reduced? ☐ Yes ☐ No

For aspirin requests:

22. Is the requested aspirin agent medically necessary? ☐ Yes ☐ No
23. 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:

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

Please continue to the next page.

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

For breast cancer prevention requests:

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

For contraceptive requests:

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

For fluoride supplementation requests:

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

For folic acid requests:

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

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

33. Is the requested PrEP agent medically necessary? ☐ Yes ☐ No
34. Does the patient have increased risk for HIV infection? ☐ Yes ☐ No
35. Has the patient recently tested negative for HIV? ☐ Yes ☐ No

For infant eye ointment requests:

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

For iron supplement requests:

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

For statin requests:

40. Is the requested statin medically necessary? ☐ Yes ☐ No
41. Is the requested statin for use in the primary prevention of cardiovascular disease (CVD)? ☐ Yes ☐ No
42. Does the patient have at least one of the following risk factors: 1) dyslipidemia, 2) diabetes, 3) hypertension, or 4) smoking? ☐ Yes ☐ No
43. 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:

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

For vaccines:

46. Is the requested vaccine medically necessary? ☐ Yes ☐ No
47. 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:
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TOLL FREE

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