

ACA PREVENTION COPAY WAIVER 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:
<p>For all requests:</p> <p>1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Is the requested agent medically necessary?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For aspirin requests:</p> <p>3. Is the patient pregnant, at high risk of preeclampsia, and using the requested agent after 12 weeks of gestation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For bowel prep requests:</p> <p>4. Will the requested agent be used for the preparation of colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For breast cancer prevention requests:</p> <p>5. Is the requested breast cancer primary prevention agent medically necessary?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Is the agent requested for the primary prevention of breast cancer?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For folic acid requests:</p> <p>7. Does the requested folic acid supplement contain 0.4-0.8 mg of folic acid?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Is the requested folic acid supplement to be used in support of pregnancy?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For HIV infection: pre-exposure prophylaxis (PrEP) requests:</p> <p>9. Is the requested agent being used for PrEP?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Does the patient have increased risk for HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has the patient recently tested negative for HIV?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For infant eye ointment requests:</p> <p>12. Is the requested agent requested for the prevention of gonococcal ophthalmia neonatorum?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please continue to the next page.</p>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For iron supplement requests:

13. Is the patient at increased risk for iron deficiency anemia? Yes No

For statin requests:

14. Is the requested statin for use in the primary prevention of cardiovascular disease (CVD)? Yes No

15. Does the patient have at least one of the following risk factors: 1) dyslipidemia, 2) diabetes, 3) hypertension, or 4) smoking? Yes No

16. 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:

17. Is the patient a non-pregnant adult? Yes No

For vaccines:

18. 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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 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

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BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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