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 for prior authorization. Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit the Blue Cross and Blue Shield of Kansas website at http://www.bcbsks.com

PATIENT AND INSURANCE INFORMATION **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 diagnosis (ICD code and description):	
Medication requested:	Strength:
Dosing schedule:	Quantity per month:

All requests:

1. Is the patient currently treated with the requested agent? ..... ☐ Yes ☐ No
2. Has the patient tried and had an inadequate response to at least TWO available formulary alternatives for the diagnosis being treated with the requested agent? ..... ☐ Yes ☐ No

   If yes, please specify agents: _____
   _____
   _____

   If yes, please provide the cause of the patient's failure to at least TWO available formulary alternatives for the diagnosis being treated with the requested agent: _____
   _____
   _____
   _____

   If no, are the available formulary alternatives contraindicated, likely to be less effective, or will cause an adverse reaction or other harm to the patient? ..... ☐ Yes ☐ No

   If yes, please explain: _____
   _____
   _____
   _____

Please continue to the next page.

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

3. Is there information that the available formulary alternatives are contraindicated, likely to be less effective, or will cause an adverse reaction or other harm to the patient? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

Brand name agent with a generic equivalent requests:

4. Has the patient tried and had an inadequate response to one or more available formulary generic equivalent(s) to the requested agent? ☐ Yes ☐ No

If yes, please specify the generic agent(s) tried: _____

If yes, please provide the cause of the patient's failure to one or more available formulary generic equivalent(s) to the requested agent: _____

_____

_____

If no, are the available formulary alternative generic equivalent(s) to the requested agent contraindicated, likely to be less effective, or will cause an adverse reaction or other harm to the patient? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

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

TOLL FREE
Fax: 877.480.8130 Phone: 866.469.5660

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