COVERAGE EXCEPTION
PRIOR AUTHORIZATION/MEDICAL NECESSITY DETERMINATION
PRESCRIBER FAX FORM

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

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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:

1. Is the patient currently treated with the requested agent?..... ☐ Yes ☐ No
2. Has the patient tried and failed at least TWO generic (MSC Y) formulary alternatives? ..... ☐ Yes ☐ No

   If yes, please specify agents: _____

   If no, are ALL available generic (MSC Y) alternatives contraindicated, likely to be less effective, or will cause an adverse reaction or other harm for the patient? ..... ☐ Yes ☐ No

   If yes, please explain: _____

   _____
3. Has the patient tried and failed TWO brand name (MSC M or N) formulary (any formulary tier) alternatives (if applicable) for the diagnosis being treated with the requested drug? ..... ☐ Yes ☐ No

   If yes, please specify agents: _____

   If no, are ALL available brand name (MSC M, or N) formulary (any formulary tier) alternatives contraindicated, likely to be less effective, or will cause an adverse reaction or other harm for the patient?..... ☐ Yes ☐ No

   If yes, please explain: _____

   _____

Please fax or mail this form to:

Horizon Blue Cross Blue Shield of New Jersey
c/o Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE

Fax: 877.897.8808 Phone: 888.214.1784

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