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
   If yes, is the patient at risk if therapy is change? ☐ Yes ☐ No
   If yes, please explain: ____________________
2. Has the patient tried and had an inadequate response to at least two formulary alternatives (any formulary tier), if available, for the diagnosis being treated with the requested agent? ☐ Yes ☐ No
   If yes, please specify agents: ____________________
   If no, are ALL available 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: ____________________

Brand name agent with a generic equivalent requests:

3. Has the patient tried and had an inadequate response to one or more available formulary generic equivalent to the requested agent? ☐ Yes ☐ No
   If yes, please specify the generic agent(s) tried: ____________________
   If no, are ALL available formulary (any formulary tier) alternative generic equivalent(s) to the requested agent 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:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE
Fax: 877.480.8130 Phone: 866.469.5660

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