PRIOR AUTHORIZATION / MEDICAL NECESSITY DETERMINATION
PRESCRIBER FAX FORM

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

Incomplete forms will be returned for additional information. Start saving time today by filling out this prior authorization form electronically. Visit www.NaviNet.net/hzdpa to register and then begin using this free service as part of your existing NaviNet account.

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
   If yes, is the patient at risk if therapy is changed? .... ☐ Yes ☐ No
   If yes, please explain: ______________________________
   ____
2. Does the patient have any FDA labeled contraindications to the requested agent? .... ☐ Yes ☐ No
3. Please list all reasons for selecting the requested agent, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, side effects, lower dose tried): ___________
   ____
   ____
4. Please list all other agents the patient is currently taking for the requested diagnosis. ______________________________
   ____
5. Please list all agents the patient has previously tried and failed for treatment of the requested diagnosis. Please specify if the patient has tried brand-name agents, generic agents, or over-the-counter (OTC) agents.
   ______________ Date(s): __________ ______________ Date(s): __________
   ______________ Date(s): __________ ______________ Date(s): __________
   ______________ Date(s): __________ ______________ Date(s): __________
6. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested diagnosis? .... ☐ Yes ☐ No
   If yes, please provide information to support therapy with a higher quantity (dose) for the requested diagnosis: _________
   ____
   If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength? .... ☐ Yes ☐ No
   If no, please explain why the requested dose cannot be optimized: ______________________________
   ____

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**

CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 888.214.1784, and return the original message to Horizon Blue Cross Blue Shield of New Jersey c/o Prime Therapeutics via U.S. Mail. Thank you for your cooperation.

 ©PRIME THERAPEUTICS LLC 01/22