

**TIER EXCEPTION REQUEST
PRIOR AUTHORIZATION/MEDICAL NECESSITY DETERMINATION
PRESCRIBER FAX FORM**

ONLY the prescriber may complete and fax 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:
<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 supported in compendia (FDA labeled, NCCN Compendium level of evidence 1 or 2A, Micromedex class I or IIa recommendation, AHFS, Clinical Pharmacology, phase III clinical trials, or a clinical study or documentation published in a major peer-reviewed medical journal supporting the requested therapeutic use) for the requested diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Is the requested agent a narrow therapeutic index (NTI) drug [e.g., Coumadin, Lanoxin, a thyroid replacement agent (e.g., Armour Thyroid, Synthroid), an anticonvulsant agent (e.g., Dilantin, Carbatrol), or an anti-rejection agent]? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">If yes, has ONE preferred agent or generic alternative been ineffective in the treatment of the patient's diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">If no, does the patient have an FDA labeled contraindication, hypersensitivity, or intolerance to ALL preferred agents and generic alternatives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have TWO preferred (i.e., tier 2) agents and two generic alternatives been ineffective in the treatment of the patient's diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">If no, does the patient have an FDA labeled contraindication, hypersensitivity, or intolerance to ALL preferred (i.e., tier 2) agents and generic alternatives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

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.