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.

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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. 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? ☐ Yes ☐ No
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]? ☐ Yes ☐ No
   - If yes, has ONE preferred agent or generic alternative been ineffective in the treatment of the patient's diagnosis? ☐ Yes ☐ No
     - If no, does the patient have an FDA labeled contraindication, hypersensitivity, or intolerance to ALL preferred agents and generic alternatives? ☐ Yes ☐ No
4. Have TWO preferred (i.e., tier 2) agents and two generic alternatives been ineffective in the treatment of the patient's diagnosis? ☐ Yes ☐ No
   - If no, does the patient have an FDA labeled contraindication, hypersensitivity, or intolerance to ALL preferred (i.e., tier 2) agents and generic alternatives? ☐ Yes ☐ No

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

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