## ACCRUFER PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

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

The following documentation is <u>REQUIRED</u>. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

## What is the priority level of this request?

Standard review Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: PATIENT AND INSURANCE INFORMATION Date of Service (if differs from Today's Date):							
Patient Name (First):	Last:				M:	-	(mm/dd/yyyy):
Patient Address:	City, State, Zip:	City, State, Zip:			Patient Telephone:		
/ember ID Number:			Group Number:				
RESCRIBER/CLINIC INFOR	RMATION						
Prescriber Name:	Prescriber NPI#:	rescriber NPI#: Specialty:		lty:	Contact Name:		
Clinic Name:		Clinic Address:					
City, State, Zip:		Phone	Phone #:		Secure Fax #:		
LEASE ATTACH ANY ADD	ITIONAL INFORMATION TH	AT SHOUL	D BE C	ONSIDERE	ED W	ІТН ТІ	
Patient's Diagnosis - ICD coo	de plus description:						
Medication Requested:				Strength:	yth:		
Dosing Schedule:		Quantity per Mo			lonth:		
For all requests:							
lf.voo minoon omonif.	-		-	-			
<ol> <li>Is the patient's age within If no, please provide r</li> </ol>	FDA labeled contraindications	s: ted indication requested a	on for th agent for	e requested	d age	nt?	 
<ol> <li>Is the patient's age within If no, please provide randomized indication:</li> <li>Are ALL other forms of indication:</li> </ol>	FDA labeled contraindications in FDA labeling for the reques rationale in support using the ron available over the counter for the patient? <b>Please note</b> ,	s: ted indication requested a - (e.g., ferro	on for th agent for us sulfa	e requested the patien	d age t's ag gluco	nt? e for t	he requested
<ul> <li>3. Is the patient's age within If no, please provide random indication:</li></ul>	FDA labeled contraindications in FDA labeling for the reques rationale in support using the ron available over the counter for the patient? <b>Please note</b> ,	s: ted indication requested a - (e.g., ferroon , <b>medical re</b>	on for th agent for us sulfa	e requested the patien te, ferrous g	d age t's ag gluco	e for t	Yes N he requested ferrous fumarate) Yes N
<ul> <li>3. Is the patient's age within If no, please provide raindication:</li> <li>4. Are ALL other forms of in not clinically appropriate If yes, please explain:</li> <li>5. Does the requested quara</li> </ul>	FDA labeled contraindications in FDA labeling for the reques rationale in support using the ron available over the counter for the patient? <b>Please note</b> ,	s: ted indication requested a (e.g., ferroon , <b>medical re</b> num FDA la	on for th agent for us sulfa ecords to beled do	e requested the patien te, ferrous g required	d age t's ag gluco	e for t nate, f	Yes N he requested ferrous fumarate) Yes N Mication? Yes N
<ol> <li>Is the patient's age within If no, please provide raindication:</li> <li>Are ALL other forms of in not clinically appropriate If yes, please explain:</li> <li>Does the requested quantion</li> <li>Can the requested quantion</li> </ol>	FDA labeled contraindications in FDA labeling for the reques rationale in support using the ron available over the counter of the patient? <b>Please note</b> ,	s: ted indication requested a r (e.g., ferroon , <b>medical re</b> num FDA la	on for th agent for us sulfa ecords i beled do tity of a	e requested the patien te, ferrous g required	d age t's ag gluco reque	e for t nate, f ested i	Yes N he requested ferrous fumarate) Yes N Mication? Yes N N bes not exceed the program

Patient Name (First):	Last:		M:	DOB (mm/dd/yyyy):						
For renewal requests:										
7. Has the patient had clinical benefit with the requested agent (e.g., stable or improvement in hemoglobin)? 🗌 Yes 🗌 No										
Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121		<b>CONFIDENTIALITY NOTICE:</b> 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								
TOLL FREE	intended recipient, you are hereby notified that any									
Phone: BCBSIL: 800.285.9426 BCBSMT: 888.723.7443 BCBSNM: 800.544.1378 BCBSOK: 800.991.5643 BCBSTX: 800.289.1525	dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.									