

ACTINIC KERATOSIS 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 **REQUIRED**. 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:	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

Please select the patient’s diagnosis:

- Actinic (solar) keratoses of the face and/or scalp
- Actinic (solar) keratoses of the trunk and/or extremities
- Superficial basal cell carcinoma
- External genital warts
- Other (ICD code and description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

- For all requests:**
- Is the patient currently treated with the requested agent?..... Yes No
If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.**..... Yes No
 - Does the patient have any FDA labeled contraindications to the requested agent?..... Yes No
If yes, please specify contraindications: _____
 - Is the patient’s age within FDA labeling for the requested indication for the requested agent? Yes No
If no, please provide support for using the requested agent for the patient’s age for the requested indication: _____
 - Is there support for therapy with the requested quantity (dose) and/or duration of therapy for the requested indication?..... Yes No
If yes, please provide supporting information: _____
 - Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer?..... Yes No
 - Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.**..... Yes No
 - If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration?..... Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
-----------------------	-------	----	-------------------

8. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

For actinic keratoses or superficial basal cell carcinoma requests:

- Please submit chart notes to support the answers to the following questions:

9. Has the patient tried and had an inadequate response to generic imiquimod 5% cream or fluorouracil solution? Yes No
10. Was generic imiquimod 5% cream or fluorouracil solution discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
11. Does the patient have an intolerance or hypersensitivity to therapy with generic imiquimod 5% cream or fluorouracil solution? Yes No
12. Does the patient have an FDA labeled contraindication to generic imiquimod 5% cream AND fluorouracil solution? Yes No
13. Is generic imiquimod 5% cream or fluorouracil solution expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
14. Is generic imiquimod 5% cream or fluorouracil solution not in the best interest of the patient based on medical necessity?..... Yes No
15. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic imiquimod 5% cream or fluorouracil solution and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No

For external genital warts:

- Please submit chart notes to support the answers to the following questions:

16. Has the patient tried and had an inadequate response to generic imiquimod 5% cream?..... Yes No
17. Was generic imiquimod 5% cream discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No
18. Does the patient have an intolerance or hypersensitivity to therapy with generic imiquimod 5% cream?..... Yes No
19. Does the patient have an FDA labeled contraindication to generic imiquimod 5% cream?..... Yes No
20. Is generic imiquimod 5% cream expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
21. Is generic imiquimod 5% cream not in the best interest of the patient based on medical necessity? Yes No
22. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic imiquimod 5% cream and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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 return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.