

BEMPEDOIC ACID 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

Patient’s Diagnosis - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently being treated with the requested agent?..... Yes No
2. Does the patient have any FDA labeled contraindications to the requested agent?..... Yes No
If yes, please specify FDA labeled contraindications: _____
3. Is the patient’s age within FDA labeling for the requested indication for the requested agent?..... Yes No
If no, please provide rationale in support of using the requested agent for the patient’s age for the requested indication: _____
4. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested indication? Yes No
If yes, please give rationale in support of therapy with a higher dose for the requested indication: _____
If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength?..... Yes No
If no, please explain: _____
5. Does the patient have a diagnosis of primary hyperlipidemia (including heterozygous familial hypercholesterolemia [HeFH])? Yes No
6. Is the patient using the requested agent to reduce the risk of myocardial infarction and coronary revascularization? Yes No
If yes, has the patient established cardiovascular disease (CVD)? Yes No
If no, does the patient have a high risk for a CVD event?..... Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>7. Has the patient tried and had an inadequate response to at least ONE statin? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">If yes, please specify statin: _____</p> <p style="margin-left: 20px;">If no, does the patient have an intolerance or hypersensitivity to statin therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">If yes, please explain intolerance or hypersensitivity: _____</p> <p style="margin-left: 40px;">_____</p> <p style="margin-left: 20px;">If no, does the patient have an FDA labeled contraindication to ALL statins? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">If yes, please specify FDA contraindication: _____</p> <p style="margin-left: 40px;">_____</p>			
For renewal requests:			
<p>8. Has the patient had clinical benefit with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121</p> <p>TOLL FREE</p>		<p>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.</p>	
<p>Phone:</p> <p>BCBSIL: 800.285.9426</p> <p>BCBSMT: 888.723.7443</p> <p>BCBSNM: 800.544.1378</p> <p>BCBSOK: 800.991.5643</p> <p>BCBSTX: 800.289.1525</p>		<p>Fax: 877.243.6930</p>	