

**CAMZYOS
PRIOR AUTHORIZATION
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 diagnosis: <input type="checkbox"/> Symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) <input type="checkbox"/> Other (ICD code and description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? Yes No
2. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? Yes No
 If yes, is the patient at risk if therapy is changed? Yes No
 If yes, please explain risk: _____
3. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify contraindications: _____
4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., cardiologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
5. Does the patient have a left ventricular ejection fraction (LVEF) of greater than or equal to 55%? Yes No
6. Does the patient have a known infiltrative or storage disorder causing cardiac hypertrophy that mimics obstructive HCM (e.g., Fabry disease, amyloidosis, Noonan syndrome with left ventricular hypertrophy)? Yes No
7. 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: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>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: _____</p> <p>_____</p>			
<p>9. Has the patient tried and had an inadequate response to ONE beta blocker? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, does the patient have an intolerance or hypersensitivity to ONE beta blocker?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain intolerance/hypersensitivity: _____</p> <p>_____</p> <p>If no, does the patient have an FDA labeled contraindication to ALL beta blockers? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication: _____</p> <p>_____</p>			
<p>10. Has the patient tried and had an inadequate response to ONE calcium channel blocker? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, does the patient have an intolerance or hypersensitivity to ONE calcium channel blocker? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain intolerance/hypersensitivity: _____</p> <p>_____</p> <p>If no, does the patient have an FDA labeled contraindication to ALL calcium channel blockers? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication: _____</p> <p>_____</p>			
For renewal requests:			
<p>11. Has the patient had clinical benefit with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Does the patient have a left ventricular ejection fraction (LVEF) of greater than or equal to 50% <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>	