

CANNABIDIOL 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:

- Seizure associated with Lennox-Gastaut syndrome (LGS)
- Seizure associated with Dravet syndrome (DS)
- Seizure associated with tuberous sclerosis complex (TSC)
- Other (ICD code, plus description): _____

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

- For all requests:**
- What is the patient's weight? _____(kg)
 - Is the patient currently treated with the requested agent? Yes No
 - Is the prescriber a specialist in the area of the patient's diagnosis (e.g. neurologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
 - Does the patient have any FDA labeled contraindication to the requested agent? Yes No
If yes, please specify FDA labeled contraindications: _____
 - Will the requested agent be used as monotherapy for seizure management? Yes No
 - Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
If no, is there support for using the requested agent for the patient's age and requested indication? Yes No
If yes, please provide supporting information: _____
 - Does the patient's medication history include the use of an anticonvulsant in the past 90 days? Yes No
If yes, please specify: _____
 - Have baseline liver transaminases and total bilirubin levels been measured? **Please note, medical records including lab results are required for initial review** Yes No
 - Will the patient's liver transaminases be monitored while the patient is on the requested agent? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
For renewal requests: 10. Has the patient had clinical benefit with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> 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		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.	
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