

CTEXLI

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 covermy meds.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: <input type="checkbox"/> Cerebrotendinous xanthomatosis (CTX) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<p>For all requests:</p> <p>1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested medication started? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____</p> <p>3. Is the patient’s age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is there support for using the requested agent for the patient’s age for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____</p> <p>4. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., 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>5. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., gastroenterologist, geneticist, hepatologist, endocrinologist, neurologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For Cerebrotendinous xanthomatosis (CTX) requests:</p> <p>6. Has the patient had genetic testing confirming variants in the CYP27A1 gene? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please continue to the next page.</p>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>7. Has the patient's diagnosis of CTX been confirmed by ALL of the following?</p> <p>a. Elevated plasma cholestanol greater than or equal to 5 to 10 times ULN (upper limit of normal)</p> <p>b. Urine positive for bile alcohols</p> <p>c. Clinical findings consistent for CTX (e.g., xanthomas [present in lungs, tendons, bone or central nervous system], infantile-onset diarrhea, childhood-onset cataract(s), adult-onset progressive neurologic dysfunction (dementia, psychiatric disturbances, pyramidal and/or cerebellar signs, dystonia, atypical parkinsonism, peripheral neuropathy, and seizures) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Has the patient had a baseline liver transaminase (alanine aminotransferase [ALT] and aspartate aminotransferase [AST]) AND total bilirubin level prior to initiating the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>For renewal requests:</p> <p>9. Is the patient monitored for changes in liver transaminase (alanine aminotransferase [ALT] and aspartate aminotransferase [AST]) AND total bilirubin level? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Does the patient have liver transaminase levels less than 3 times the upper limit of normal (ULN)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Does the patient have a total bilirubin level less than 2 times the ULN? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. 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 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: BCBSIL: 800.285.9426 BCBSMT: 888.723.7443 BCBSNM: 800.544.1378 BCBSOK: 800.991.5643 BCBSTX: 800.289.1525</p>	<p>Fax: 877.243.6930</p>		