

**DOJOLVI  
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](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://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: <input type="checkbox"/> Long-chain fatty acid oxidation disorder (LCFAOD) <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. Does the patient have any FDA labeled contraindications to the requested agent? .....  Yes  No  
If yes, please specify contraindications: \_\_\_\_\_
3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., endocrinologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? .....  Yes  No
4. Has the diagnosis been confirmed by TWO of the following: 1) disease-specific elevations of acylcarnitines on a newborn blood spot or in plasma, 2) enzyme activity assay (in cultured fibroblasts or lymphocytes) demonstrating deficiency of an enzyme associated with LCFAODs, or 3) genetic testing demonstrating pathogenic mutation in a gene associated with LCFAODs? .....  Yes  No
5. Did the patient have symptomatic LCFAOD prior to therapy with the requested agent? .....  Yes  No
6. Will the patient be using the requested agent in combination with another medium chain triglyceride product for the requested indication? .....  Yes  No
7. Will the patient be using the requested agent for more than 35% of their total prescribed daily caloric intake?...  Yes  No
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:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For renewal requests:**

9. Has the patient had clinical benefit with the requested agent? .....  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**

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