

DUVYZAT

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: <input type="checkbox"/> Duchenne muscular dystrophy (DMD) <input type="checkbox"/> Other (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? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent? A contraindication is a medical situation where a treatment should be avoided because it could cause harm to a person. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ _____	
3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., pediatric 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	
4. 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, please provide support for using the requested agent for the patient's age for the requested indication: _____ _____	
5. 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):
For Duchenne muscular dystrophy (DMD) requests:			
6. Has the patient's diagnosis been confirmed by genetic analysis (i.e., dystrophin deletion or duplication mutation)? Please note, genetic test results are required. <input type="checkbox"/> Yes <input type="checkbox"/> No			
7. Is the patient ambulatory? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Has the patient been stable on corticosteroid therapy used to treat DMD for at least 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please specify agent: _____			
If yes, will the patient continue to be on corticosteroid therapy for DMD while taking the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, does the patient have an intolerance or hypersensitivity to corticosteroids used to treat DMD? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain intolerance/hypersensitivity: _____			

If no, does the patient have an FDA labeled contraindication to ALL corticosteroids used to treat DMD? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please specify FDA labeled contraindication: _____			

For renewal requests:			
9. Has the patient had improvements or stabilization with the requested agent (e.g., slowed disease progression, improved strength, timed motor function, pulmonary function; reduced need for scoliosis surgery)? <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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