

ENDARI

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"/> Sickle cell disease <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. What is the patient’s weight? _____ 2. Is the patient currently being treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Does the patient have any FDA labeled contraindications to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindication(s): _____ _____ 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, is there support for the use of the requested agent for the patient’s age? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____ _____ 5. Will the patient be using the requested agent in combination with Adakveo (crizanlizumab-tmca)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____ _____ 6. Please list all reasons for selecting the requested medication, 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): _____ _____ _____	
For sickle cell disease: 7. Is the patient using the requested agent to reduce the acute complications of sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For sickle cell disease continued:

8. Has the patient tried and had an inadequate response after at least 6 months duration of therapy with maximally tolerated hydroxyurea? **Please note, chart notes are required.** Yes No
 If no, does the patient have an intolerance or hypersensitivity to hydroxyurea? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to hydroxyurea? Yes No
 If yes, please specify FDA labeled contraindication: _____

For Endari (brand agent) requests:

9. Is the patient currently being treated with the requested agent, AND the patient is currently stable on the requested agent?
Please note, chart notes are required...... Yes No
 If no, has the patient tried and had an inadequate response to the generic equivalent (L-glutamine)? **Please note, chart notes are required.**..... Yes No
 If no, was the generic equivalent (L-glutamine) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? **Please note, chart notes are required.**..... Yes No
 If no, does the patient have an intolerance or hypersensitivity to the generic equivalent (L-glutamine) that is NOT expected to occur with the brand agent? **Please note, chart notes are required.**..... Yes No
 If yes, please explain intolerance or hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to the generic equivalent (L-glutamine) that is NOT expected to occur with the brand agent?
Please note, chart notes are required. Yes No
 If yes, please specify contraindication: _____

 If no, is there support for the use of the requested brand agent over the generic equivalent? Yes No
 If yes, please provide supporting information: _____

10. Are ONE of the following expected of the generic equivalent (L-glutamine)? **Please note, chart notes are required.** Yes No
1. To be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug
 2. Cause a significant barrier to the patient's adherence of care
 3. Worsen a comorbid condition
 4. Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities
 5. Cause an adverse reaction or cause physical or mental harm
- If no, Is the generic equivalent (L-glutamine) not in the best interest of the patient based on medical necessity? **Please note, chart notes are required.**..... Yes No
 If no, Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the generic equivalent (L-glutamine), AND that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? **Please note, chart notes are required.** Yes No
 If no, is there support for the use of the requested brand agent over the generic equivalent (L-glutamine)? Yes No
 If yes, please provide supporting information: _____

Please continue to the next page.

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

11. Has the patient had clinical benefit with the requested agent (e.g., reduction in acute complications of sickle cell disease since initiating therapy 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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