

# EOHILIA 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"/> Eosinophilic esophagitis (EoE) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b> 1. Is the patient currently 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? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindication(s): _____ _____	
3. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., gastroenterologist, allergist, immunologist), 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, 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 support: _____ _____	
5. 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). _____ _____ _____	
<b>For eosinophilic esophagitis (EoE) requests:</b> 6. Has the patient’s diagnosis been confirmed by ALL of the following: 1) chronic symptoms of esophageal dysfunction, 2) greater than or equal to 15 eosinophils per high-power field on esophageal biopsy, and 3) other causes that may be responsible for or contributing to symptoms and esophageal eosinophilia have been ruled out? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>7. Has the patient tried and had an inadequate response to ONE standard corticosteroid therapy (i.e., swallowed budesonide nebulizer suspension, swallowed fluticasone from a metered dose inhaler [MDI]) used in the treatment of EoE after at least an 8-week duration of therapy?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">If no, does the patient have an intolerance or hypersensitivity to ONE standard corticosteroid therapy used in the treatment of EoE that is not expected to occur with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">If yes, please explain intolerance/hypersensitivity: _____</p> <p style="margin-left: 40px;">_____</p> <p style="margin-left: 40px;">If no, does the patient have an FDA labeled contraindication to ALL standard corticosteroid therapies used in the treatment of EoE that is not expected to occur with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">If yes, please specify FDA labeled contraindication: _____</p> <p style="margin-left: 40px;">_____</p> <p>8. Has the patient tried and had inadequate response to ONE proton pump inhibitor (PPI) used in the treatment of EoE after at least an 8-week duration of therapy?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">If no, does the patient have an intolerance or hypersensitivity to ONE PPI used in the treatment of EoE? .. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">If yes, please explain intolerance/hypersensitivity: _____</p> <p style="margin-left: 40px;">_____</p> <p style="margin-left: 40px;">If no, does the patient have an FDA labeled contraindication to ALL PPIs used in the treatment of EoE? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">If yes, please specify FDA labeled contraindication: _____</p> <p style="margin-left: 40px;">_____</p> <p>9. Has the patient been treated with a course of therapy (12 weeks) with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">If yes, is there support for an additional course of therapy with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 40px;">If yes, please provide support: _____</p> <p style="margin-left: 40px;">_____</p>			
<b>Please fax or mail this form to:</b> Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121 <b>TOLL FREE</b>		<b>CONFIDENTIALITY NOTICE:</b> 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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