

FILSUEVZ

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"/> Dystrophic or junctional epidermolysis bullosa <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? Yes No
2. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify FDA labeled contraindications: _____
3. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., dermatologist, geneticist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? Yes No
4. Is the patient’s age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, please provide rationale in support of using the requested agent for the patient’s age for the requested indication: _____
5. Does the patient have current evidence or a history of squamous cell carcinoma on the area to be treated ? ... Yes No
6. Does the patient have an active infection on the area to be treated? Yes No

For dystrophic or junctional epidermolysis bullosa requests:

7. Has the patient’s diagnosis been confirmed by genetic testing? **Medical records are required.** Yes No
8. Will the patient be using the requested agent in combination with a gene therapy agent on the area to be treated? Yes No

Please continue to the next page.

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
| For renewal requests: 9. Has the patient had clinical benefit with the requested agent? <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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