

# HARLIKU

## PRIOR AUTHORIZATION

### 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 [covermy meds.com](http://covermy meds.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"/> Alkaptonuria <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<p><b>For all requests:</b></p> <p>1. Is the patient currently treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, is the patient currently stable on the requested agent? <b>Please note, chart notes are required.</b>..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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 contraindication(s): _____</p> <p>3. 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 supporting information: _____</p> <p>4. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., geneticist, rheumatologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Are there medical records that show the patient has greater than or equal to 1 gram of homogentisic acid (HGA) in a 24-hour urine sample? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, please submit medical records.</p> <p>6. Please list all reasons for selecting the requested agent, 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>Please note, documentation may be required:</b> _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p><b>Please continue to the next page.</b></p>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
-----------------------	-------	----	-------------------

**Medical records including chart notes are required for the following questions:**

7. Has the patient tried and had an inadequate response to TWO prerequisite agents (i.e., nitisinone capsule, Nityr tablet) that is NOT expected to occur with the requested agent? .....  Yes  No
8. Were the TWO prerequisite agents (i.e., nitisinone capsule, Nityr tablet) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
9. Does the patient have an intolerance or hypersensitivity to TWO prerequisite agents (i.e., nitisinone capsule, Nityr tablet) that is NOT expected to occur with the requested agent? .....  Yes  No
10. Does the patient have an FDA labeled contraindication to ALL prerequisite agents (i.e., nitisinone capsule, Nityr tablet) that is NOT expected to occur with the requested agent? .....  Yes  No
11. Are the TWO prerequisite agents (i.e., nitisinone capsule, Nityr tablet) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? .....  Yes  No
12. Are the TWO prerequisite agents (i.e., nitisinone capsule, Nityr tablet) NOT in the best interest of the patient based on medical necessity? .....  Yes  No
13. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as TWO prerequisite agents (i.e., nitisinone capsule, Nityr tablet) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

**For renewal requests:**

14. Are there medical records that show the patient has had clinical benefit with the requested agent as indicated by a reduction in urinary homogentisic acid? .....  Yes  No  
If yes, please submit medical records.

**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**

**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.