

# HYFTOR

## 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"/> Tuberos scleros complex (TSC) <input type="checkbox"/> Other (ICD code and description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b>	
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?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ _____	
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, please provide rationale in support of using the requested agent for the patient’s age for the requested indication: _____ _____	
4. Is the requested quantity (dose) greater than the maximum FDA labeled dose for the requested indication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give rationale in support of therapy with a higher dose for the requested indication: _____ _____ If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____ _____	
5. 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? ..... <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>6. Does the patient have a diagnosis of tuberous sclerosis complex (TSC) confirmed by ONE of the following:</p> <ul style="list-style-type: none"> <li>• 1) The patient has two major features OR one major and two minor features of TSC clinical diagnostic criteria (Major features: hypomelanotic macules [greater than or equal to 3, at least 5 mm diameter], angiofibroma [greater than or equal to 3] or fibrous cephalic plaque, unguis fibromas [greater than or equal to 2], shagreen patch, multiple retinal hamartomas, multiple cortical tubers and/or radial migration lines, subependymal nodule [greater than or equal to 2], subependymal giant cell astrocytoma, cardiac rhabdomyoma, lymphangiomyomatosis (LAM)*, angiomyolipomas* [greater than or equal to 2]; note that a combination of LAM and angiomyolipomas, without other features, does not meet the criteria for a definite diagnosis. Minor features: "confetti" skin lesions, dental enamel pits [greater than or equal to 3], intraoral fibromas [greater than or equal to 2], retinal achromic patch, multiple renal cysts, nonrenal hamartomas, sclerotic bone lesions).</li> <li>• 2) The patient has a pathogenic variant in the TSC1 gene or TSC2 gene confirmed by genetic testing? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <p>7. Does the patient have three or more facial angiofibromas that are at least 2 mm in diameter with redness in each? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p><b>For renewal requests:</b></p> <p>8. Has the patient had clinical benefit with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<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</p> <p><b>TOLL FREE</b></p>		<p><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.</p>	
<p><b>Phone:</b>  <b>BCBSIL: 800.285.9426</b>  <b>BCBSMT: 888.723.7443</b>  <b>BCBSNM: 800.544.1378</b>  <b>BCBSOK: 800.991.5643</b>  <b>BCBSTX: 800.289.1525</b></p>	<p><b>Fax: 877.243.6930</b></p>		