

IBS-D 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:

Hepatic Encephalopathy
 Irritable bowel syndrome with diarrhea (IBS-D)
 Other (ICD code, plus description): _____

Medication Requested:	Strength:
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Dosing Schedule:	Quantity per Month:
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For all requests:

1. Is the patient currently being treated with the requested agent? Yes No
 If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required** 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 patient's age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, please provide support for using the requested agent for the patient's age for the requested indication: _____

4. Is the patient at risk of recurrent overt hepatic encephalopathy? Yes No

5. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>For IBS-D requests:</p> <p>6. Is the requested dosage strength FDA labeled for the requested FDA labeled indication OR supported in compendia (AHFS or DrugDex 1 or 2a level of evidence) for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, is there support for the requested dosage strength for the requested FDA labeled or compendia (AHFS or DrugDex 1 or 2a level of evidence) supported indication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For Travelers' Diarrhea:</p> <p>7. Is the patient's travelers' diarrhea cause by noninvasive strains of Escherichia coli? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does the patient have diarrhea complicated by fever or blood in the stool OR diarrhea due to pathogens other than Escherichia coli?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Is the requested dosage strength FDA labeled for the requested FDA labeled indication OR supported in compendia (AHFS or DrugDex 1 or 2a level of evidence) for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, is there support for the requested dosage strength for the requested FDA labeled or compendia (AHFS or DrugDex 1 or 2a level of evidence) supported indication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121</p> <p>TOLL FREE</p>		<p>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.</p>	
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