ISTURISA
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:

☐ Cushing's syndrome

☐ 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
   If yes, is the patient is currently stable on the requested agent? **Please note, chart notes are required.** ☐ Yes ☐ No
2. Does the patient have any FDA contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindication: ________________
3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., endocrinologist), 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 support for using the requested agent for the patient's age for the requested indication: ________________
5. Will the patient be using the requested agent in combination with glucocorticoid replacement therapy? ☐ Yes ☐ No
6. 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:** ________________
7. Has the patient had an inadequate response to surgery? ☐ Yes ☐ No
   If no, is the patient a candidate for surgery? ☐ Yes ☐ No

Please continue to the next page.

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

8. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? ☐ Yes ☐ No
9. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.** ☐ Yes ☐ No
10. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? ☐ Yes ☐ No

Please submit chart notes to support the answers to the following questions:

11. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., mifepristone, Signifor/Signifor LAR (pasireotide), Recorlev (levoketoconazole), cabergoline, metyrapone, Lysodren (mitotane))? ☐ Yes ☐ No
12. Were mifepristone, Signifor/Signifor LAR (pasireotide), Recorlev (levoketoconazole), cabergoline, metyrapone, OR Lysodren (mitotane) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
13. Does the patient have an intolerance or hypersensitivity to mifepristone, pasireotide, or levoketoconazole? ☐ Yes ☐ No
14. Does the patient have an FDA labeled contraindication to mifepristone, pasireotide, and levoketoconazole? ☐ Yes ☐ No
15. Are mifepristone, pasireotide, or levoketoconazole 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
16. Are mifepristone, pasireotide, or levoketoconazole not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
17. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as mifepristone, Signifor/Signifor LAR (pasireotide), Recorlev (levoketoconazole), cabergoline, metyrapone, OR Lysodren (mitotane) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
18. Has the patient tried and had an inadequate response to ketoconazole tablets? ☐ Yes ☐ No
19. Were ketoconazole tablets discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
20. Does the patient have an intolerance or hypersensitivity to ketoconazole tablets? ☐ Yes ☐ No
21. Does the patient have an FDA labeled contraindication to ketoconazole tablets? ☐ Yes ☐ No
22. Are ketoconazole tablets 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
23. Are ketoconazole tablets not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
24. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ketoconazole tablets and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

For renewal requests:

25. Has the patient had clinical benefit with the requested agent? ☐ Yes ☐ No

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
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Eagan, MN 55121

TOLL FREE

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BCBSNM: 800.544.1378
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