

**JOENJA
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"/> Activated phosphoinositide 3-kinase (PI3K) delta syndrome (APDS) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests:	
1. What is the patient’s weight? _____ (kg)	
2. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. 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 contraindication(s): _____	
4. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., geneticist, immunologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. 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 support for using the requested agent for the patient’s age for the requested indication: _____	
6. Does the patient have a variant in either PIK3CD or PIK3R1? Please note, chart notes are required. <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. 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: _____ _____ _____	
8. _____	
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

Phone:

BCBSIL: 800.285.9426

BCBSMT: 888.723.7443

BCBSNM: 800.544.1378

BCBSOK: 800.991.5643

BCBSTX: 800.289.1525

Fax: 877.243.6930

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