

OHTUVAYRE

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"/> Chronic obstructive pulmonary disease (COPD) <input type="checkbox"/> 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
2. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify contraindications: _____
3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, pulmonologist), 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. 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:** _____

For chronic obstructive pulmonary disease (COPD) requests:

6. Was the patient's diagnosis confirmed by spirometry with a post-bronchodilator FEV1/FVC ratio less than 0.7? Yes No
7. Does the patient have a post-bronchodilator FEV1 between 30% to 70% predicted? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>For chronic obstructive pulmonary disease (COPD) requests (continued):</p> <p>8. Does the patient have a modified Medical Research Council dyspnea (mMRC) score of 2 or greater? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, does the patient have a COPD Assessment Test (CAT) score greater than or equal to 10? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Is the patient currently being treated with a long-acting beta-2 agonist (LABA) + long-acting muscarinic antagonist (LAMA) combination with or without an inhaled corticosteroid (ICS)? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, does the patient have an intolerance or hypersensitivity to a LABA + LAMA combination? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain intolerance/hypersensitivity: _____ _____</p> <p>If no, does the patient have an FDA labeled contraindication to ALL LABA + LAMA combinations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication: _____ _____</p> <p>10. Will the patient continue COPD control therapy (e.g., LABA, LAMA, ICS) in combination with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>For renewal requests:</p> <p>11. Has the patient had clinical benefit with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>For chronic obstructive pulmonary disease (COPD) renewal requests:</p> <p>12. Has the patient had a decrease in exacerbations and/or dyspnea with the requested agent? <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>	
<p>Phone: Fax: 877.243.6930</p> <p>BCBSIL: 800.285.9426 BCBSMT: 888.723.7443 BCBSNM: 800.544.1378 BCBSOK: 800.991.5643 BCBSTX: 800.289.1525</p>			