PRIOR AUTHORIZATION
STEP THERAPY
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 - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

1. What is the patient's weight? _____ (kg) What is the patient's height? _____ (cm)
2. Is the patient currently being treated with the requested agent?..... ☐ Yes ☐ No
3. Does the patient have any FDA labeled contraindications to the requested agent? ..... ☐ Yes ☐ No
4. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max).
   _____
   _____
5. Please list other medications the patient will use in combination with the requested medication for treatment of this diagnosis.
   _____
   _____
6. Please list all medications the patient has previously tried and failed for treatment of this diagnosis**.** (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.)

_____	Date(s): _____	_____	Date(s):_____
_____	Date(s): _____	_____	Date(s):_____
_____	Date(s): _____	_____	Date(s):_____

*****MEDICAL RECORDS INCLUDING CHART NOTES ARE REQUIRED FOR THIS REQUEST*****

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525