

PANCREATIC ENZYMES 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 covermyeds.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:

For all requests:

1. What is the patient’s weight? _____ (kg)
2. 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
3. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)?..... Yes No
 If yes, is the patient at risk if therapy is changed?..... Yes No
 If yes, please specify risk: _____

4. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify FDA labeled contraindications: _____

5. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., cystic fibrosis, gastroenterologist) or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? Yes No
6. If the request is for Viokace, will the patient take with a proton pump inhibitor (PPI)? Yes No
7. Does the requested quantity (dose) exceed 10,000 units/kg/day?..... Yes No
 If yes, please provide information in support of therapy with a higher dose for the requested indication: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For Pancreaze, Pertzye, or Viokace requests:

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

7. Has the patient tried and had an inadequate response to both Creon and Zenpep? Yes No
8. Were both Creon and Zenpep discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
9. Does the patient have an intolerance or hypersensitivity to both Creon and Zenpep that is not expected to occur with the requested agent? Yes No
10. Does the patient have an FDA labeled contraindication to both Creon and Zenpep that is not expected to occur with the requested agent? Yes No
11. Are both Creon and Zenpep 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
12. Are both Creon and Zenpep not in the best interest of the patient based on medical necessity? Yes No
13. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as both Creon and Zenpep and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

For renewal requests:

8. 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
 2900 Ames Crossing Road Suite 200
 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

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