QUANTITY EXCEPTION
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:
Length of Therapy Requested:	

Please provide the following:

Body surface area (BSA):_____ m2 Weight:_____ kg Height:_____ cm

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
   If no, is the patient new to therapy? ☐ Yes ☐ No
2. Does the requested quantity/dose/duration exceed the maximum FDA labeled dose for the requested indication? ☐ Yes ☐ No
   If no, can the prescribed dose be achieved with a lower quantity of a higher strength? ☐ Yes ☐ No
   If no, please explain: _____
   _____
   If no, is the dosage increase requested appropriate based on recommended dosage titrations in FDA labeling or Compendia (i.e., dosage increase is not excessive, patient has been on current dose a sufficient length of time to determine efficacy/adverse effects)? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
3. Please submit documentation in support of therapy for an accepted diagnosis for exception (accepted documentation will include documentation from approved compendia, published Phase III clinical trials showing benefit): _____
   _____

For glucose test strips/disks:

4. Is the patient prescribed insulin administered by multiple daily injections or infusion pump? ☐ Yes ☐ No
   If yes, please explain: _____

For insomnia agents

5. Is the intent to switch medication therapy? ☐ Yes ☐ No
   If yes, please explain: _____

Please continue to the next page.

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

For ophthalmic prostaglandins:

6. Is wastage significant but unable to be avoided (the patient or care giver is not able to properly instill eye drops without excess wastage)? ☐ Yes ☐ No

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

TOLL FREE

Phone: **Fax: 877.243.6930**
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BCBSNM: 800.544.1378
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