

# 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](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://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

- Is the patient currently treated with the requested agent? .....  Yes  No  
 If no, is the patient new to therapy? .....  Yes  No
- 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, 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
- 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:**

- Is the patient prescribed insulin administered by multiple daily injections or infusion pump? .....  Yes  No  
 If yes, please explain: \_\_\_\_\_

**For insomnia agents**

- 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):
<p><b>For low molecular weight heparins (LMWH), heparins and Arixtra:</b></p> <p>6. Does the patient require extended treatment for primary or secondary prophylaxis of thromboembolism during pregnancy and/or puerperium? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Does the patient have cancer and requires extended prophylaxis and/or treatment of symptomatic VTE (DVT and/or PE), to reduce the recurrence of VTE?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>For ophthalmic prostaglandins:</b></p> <p>8. Is wastage significant but unable to be avoided (the patient or care giver is not able to properly instill eye drops without excess wastage)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>For topical estrogens:</b></p> <p>9. Is the request for transgender support? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p><b>Please fax or mail this form to:</b>  Prime Therapeutics LLC  Clinical Review Department  2900 Ames Crossing Road  Eagan, MN 55121</p> <p><b>TOLL FREE</b></p>		<p><b>CONFIDENTIALITY NOTICE:</b> 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><b>Phone:</b>  <b>BCBSIL: 800.285.9426</b>  <b>BCBSMT: 888.723.7443</b>  <b>BCBSNM: 800.544.1378</b>  <b>BCBSOK: 800.991.5643</b>  <b>BCBSTX: 800.289.1525</b></p>	<p><b>Fax: 877.243.6930</b></p>		