

# RECORLEV

## 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](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: <input type="checkbox"/> Cushing's syndrome <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

- 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
- Does the patient have any FDA labeled contraindications to the requested agent?.....  Yes  No  
If yes, please specify contraindications: \_\_\_\_\_
- Is the prescriber a specialist in the area of the patient's diagnosis (e.g., endocrinologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? .....  Yes  No
- Has the patient had an inadequate response to surgery? .....  Yes  No  
If no, is the patient a candidate for surgery? .....  Yes  No
- Will the patient be using the requested agent in combination with glucocorticoid replacement therapy for the requested indication? .....  Yes  No
- Has the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer?.....  Yes  No
- Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.** .....  Yes  No
- If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? .....  Yes  No

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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9. 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:** \_\_\_\_\_

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

10. Has the patient tried and had an inadequate response to at least ONE of the following conventional agents: 1) mifepristone, 2) Signifor/Signifor LAR (pasireotide), 3) Isturisa (osilodrostat), 4) cabergoline, 5) metyrapone, or 6) Lysodren (mitotane)? .....  Yes  No
11. Did the patient discontinue mifepristone, pasireotide, osilodrostat, cabergoline, metyrapone, or mitotane due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
12. Does the patient have an intolerance or hypersensitivity to mifepristone, pasireotide, or osilodrostat? .....  Yes  No
13. Does the patient have an FDA labeled contraindication to mifepristone, pasireotide AND osilodrostat? .....  Yes  No
14. Is mifepristone, pasireotide, or osilodrostat 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
15. Is mifepristone, pasireotide, or osilodrostat not in the best interest of the patient based on medical necessity?..  Yes  No
16. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as mifepristone, pasireotide, osilodrostat, cabergoline, metyrapone, or mitotane and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
17. Has the patient tried and had an inadequate response to ketoconazole tablets? .....  Yes  No
18. Were ketoconazole tablets discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
19. Does the patient have an intolerance or hypersensitivity to ketoconazole tablets that is NOT expected to occur with the requested agent? .....  Yes  No
20. Does the patient have an FDA labeled contraindication to ketoconazole tablets that is NOT expected to occur with the requested agent? .....  Yes  No
21. Are ketoconazole tablets 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
22. Are ketoconazole tablets not in the best interest of the patient based on medical necessity? .....  Yes  No
23. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ketoconazole tablets and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

**For all requests:**  
 24. 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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