

SKYCLARYS

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 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

Please select the patient's diagnosis:

Friedreich ataxia (FA, FRDA)
 Other (ICD code, plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

- Has the patient been treated with the requested agent? Yes No
- Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify contraindication(s): _____
- Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, please provide support for using the requested agent for the patient's age for the requested indication: _____
- Is the prescriber a specialist in the area of the patient's diagnosis (e.g., cardiologist, geneticist, neurologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
- Has the patient's diagnosis been confirmed by genetic analysis confirming mutation in the frataxin (FXN) gene? **Please note, chart notes are required.** Yes No
- 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 continue to the next page.

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

7. 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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