

TARPEYO

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 covermy meds.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: <input type="checkbox"/> Primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

- Is the patient currently 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 FDA labeled contraindications: _____
- Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
 If yes, 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 (such as a nephrologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
- Will the requested agent be used to reduce the loss of kidney function in a patient at risk for disease progression? Yes No
- Does the patient have a urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.44 g/g? Yes No
 If yes, please specify lab value: _____
 If no, does the patient have proteinuria greater than or equal to 0.5 g/day? Yes No
 If yes, please specify lab value: _____
- Is the patient's eGFR is greater than or equal to 30 mL/min/1.73 m²? Yes No
 If yes, please specify lab value: _____
- Has the patient been previously treated with a course of therapy (9 months) with the requested agent? Yes No
 If yes, is there support for an additional course of therapy with the requested agent? Yes No
 If yes, please provide support: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>9. Has the patient tried and had an inadequate response after at least a 3 month duration of therapy with a maximally tolerated angiotensin-converting enzyme inhibitor (ACEi, e.g., benazepril, lisinopril) or angiotensin II blocker (ARB, e.g., losartan), or a combination medication containing an ACEi or ARB?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If no, does the patient have an intolerance or hypersensitivity to an ACEi or ARB?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">If yes, please explain intolerance/hypersensitivity: _____</p> <p style="padding-left: 40px;">_____</p> <p style="padding-left: 20px;">If no, does the patient have an FDA labeled contraindication to ALL ACEi or ARB?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">If yes, please specify FDA labeled contraindication: _____</p> <p style="padding-left: 40px;">_____</p>			
<p>10. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____</p> <p>_____</p> <p>_____</p>			
<p>Please submit chart notes to support the answers to the following questions:</p>			
<p>11. Has the patient tried and had an inadequate response to ONE oral generic glucocorticoid? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>12. Was ONE oral generic glucocorticoid discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>13. Does the patient have an intolerance or hypersensitivity to ONE oral generic glucocorticoid that is not expected to occur with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>14. Does the patient have an FDA labeled contraindication to ALL oral generic glucocorticoids that is not expected to occur with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>15. Is ONE oral generic glucocorticoid 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>16. Is ONE oral generic glucocorticoid not in the best interest of the patient based on medical necessity?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>17. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE oral generic glucocorticoid and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121 TOLL FREE</p>		<p>CONFIDENTIALITY NOTICE: 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>Phone: BCBSIL: 800.285.9426 BCBSMT: 888.723.7443 BCBSNM: 800.544.1378 BCBSOK: 800.991.5643 BCBSTX: 800.289.1525</p>		<p>Fax: 877.243.6930</p>	