

# VERQUVO

## 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"/> Symptomatic chronic heart failure (NYHA class II-IV) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b> 1. Is the patient currently being treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Has the patient been treated with the requested agent (starting on samples is not approvable) within the past 90 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ 3. Does the patient have any FDA labeled contraindication to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., cardiologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Is the patient's age within FDA labeling for the requested indication for the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide rationale in support of using the requested agent for the patient's age for the requested indication: _____ 6. Does the patient have a left ventricular ejection fraction (LVEF) less than 45%?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Has the patient had hospitalization for heart failure within the past 6 months? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Has the patient used outpatient IV diuretics for heart failure within the past 3 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Is the requested quantity (dose) greater than the maximum FDA labeled dose for the requested indication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide rationale in support of therapy with a higher dose for the requested indication: _____ If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____	
<b>Please continue to the next page.</b>	

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

10. 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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