

**VTAMA  
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"/> Atopic dermatitis (AD) <input type="checkbox"/> Plaque psoriasis (PS) <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 If yes, is the patient currently stable on the requested agent ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please submit chart notes 2. Does the patient have any FDA labeled contraindications to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindications: _____ _____ 3. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., dermatologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 4. 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 support for using the requested agent for the patient’s age for the requested indication: _____ _____ 5. 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). <b>Please note, documentation may be required:</b> _____ _____ _____	
<b>Please continue to the next page.</b>	

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

- **Please submit chart notes for the following questions (questions 6-12)**

- Has the patient tried and had an inadequate response to ONE at least low-potency topical corticosteroid OR topical calcineurin inhibitor used in treatment of AD after at least a 4-week duration of therapy? .....  Yes  No
- Was ONE at least low-potency topical corticosteroid OR topical calcineurin inhibitor used in treatment of AD discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
- Does the patient have an intolerance or hypersensitivity to ONE at least low-potency topical corticosteroid OR topical calcineurin inhibitor used in treatment of AD? .....  Yes  No
- Does the patient have an FDA labeled contraindication to ALL low-potency topical corticosteroids OR ALL topical calcineurin inhibitors used in treatment of AD? .....  Yes  No
- Is ONE at least low-potency topical corticosteroid OR topical calcineurin inhibitor used in treatment of AD 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
- Is ONE at least low-potency topical corticosteroid OR topical calcineurin inhibitor used in treatment of AD not in the best interest of the patient based on medical necessity? .....  Yes  No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE at least low-potency topical corticosteroid OR topical calcineurin inhibitor used in treatment of AD and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
- Is the patient currently treated with topical emollients and practicing good skin care?.....  Yes  No  
If yes, Will the patient continue the use of topical emollients and good skin care practices in combination with the requested agent? .....  Yes  No

**For plaque psoriasis requests:**

- Has the patient tried and had an inadequate response to ONE topical corticosteroid OR topical calcineurin inhibitor used in the treatment of plaque psoriasis after at least a 2-week duration of therapy?.....  Yes  No  
If yes, please specify agent tried: \_\_\_\_\_  
If no, does the patient have an intolerance or hypersensitivity to ONE topical corticosteroid OR topical calcineurin inhibitor used in the treatment of plaque psoriasis?.....  Yes  No  
If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
If no, does the patient have an FDA labeled contraindication to ALL topical corticosteroids and topical calcineurin inhibitors used in the treatment of plaque psoriasis? .....  Yes  No  
If yes, please specify FDA labeled contraindication(s): \_\_\_\_\_

**For renewal requests:**

- Has the patient had clinical benefit with the requested agent? .....  Yes  No

**For atopic dermatitis requests:**

- Will the patient continue standard maintenance therapies (e.g., topical emollients, good skin care practices) in combination 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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