

# WINLEVI

## PRIOR AUTHORIZATION

### 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 [covermy meds.com](http://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**

|   |                     |
|---|---------------------|
| Patient’s Diagnosis:<br><input type="checkbox"/> Acne vulgaris<br><input type="checkbox"/> Other (ICD code plus description): _____   |                     |
| Medication Requested:   | Strength:           |
| Dosing Schedule:  | Quantity per Month: |
| <p><b>For all requests:</b></p> <p>1. Is the patient currently treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Is the patient’s age within FDA labeling for the requested indication for the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If no, is there support for using the requested agent for the patient's age for the requested indication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If yes, please provide supporting information: _____</p> <p>3. Has the patient tried and had an inadequate response to ONE generic topical antibiotic used in the treatment of acne? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If yes, please specify agent tried: _____<br/>         If no, has the patient tried and had an inadequate response to ONE generic topical retinoid used in the treatment of acne? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If yes, please specify agent tried: _____<br/>         If no, does the patient have an intolerance or hypersensitivity to ONE generic topical antibiotic or generic topical retinoid used in the treatment of acne? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If yes, please explain intolerance/hypersensitivity: _____</p> <p>If no, does the patient have an FDA labeled contraindication to ALL generic topical antibiotics AND generic topical retinoids used in the treatment of acne?..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If yes, please specify FDA labeled contraindication: _____</p> |                     |
| <p><b>Please continue to the next page.</b></p>   |                     |

|   |                          |  |                   |
|---|--------------------------|--|-------------------|
| Patient Name (First):   | Last:                    | M:   | DOB (mm/dd/yyyy): |
| <b>Please fax or mail this form to:</b><br>Prime Therapeutics LLC<br>Clinical Review Department<br>2900 Ames Crossing Road Suite 200<br>Eagan, MN 55121<br><b>TOLL FREE</b> |                          | <b>CONFIDENTIALITY NOTICE:</b> 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. |                   |
| <b>Phone:</b><br><b>BCBSIL: 800.285.9426</b><br><b>BCBSMT: 888.723.7443</b><br><b>BCBSNM: 800.544.1378</b><br><b>BCBSOK: 800.991.5643</b><br><b>BCBSTX: 800.289.1525</b>    | <b>Fax: 877.243.6930</b> |  |                   |