

**ZELSUVMI
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. 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

Patient’s Diagnosis: <input type="checkbox"/> Molluscum contagiosum (MC) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 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 contraindication(s): _____ _____	
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. Will the patient be using the requested agent in combination with another conventional therapy (e.g., cantharidin, cryotherapy, curettage or podofilox) for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? Please note, chart notes are required. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please submit chart notes. If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>6. Has the patient tried and had an inadequate response to ONE conventional therapy (e.g., cantharidin, cryotherapy, curettage, podofilox)? <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 ONE conventional therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, please explain intolerance/hypersensitivity: _____</p> <p style="padding-left: 20px;">_____</p> <p style="padding-left: 20px;">If no, does the patient have an FDA labeled contraindication to ALL conventional therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, please specify FDA labeled contraindication: _____</p> <p style="padding-left: 20px;">_____</p> <p style="padding-left: 20px;">If no, is there support that conventional therapy is not recommended for the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, please provide supporting information: _____</p> <p style="padding-left: 20px;">_____</p> <p>7. Is the patient's age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">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</p> <p style="padding-left: 20px;">If yes, please provide supporting information: _____</p> <p style="padding-left: 20px;">_____</p> <p>8. Please list all reasons for selecting the requested agent, 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>_____</p>			
<p>Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121</p> <p>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:</p> <p>BCBSIL: 800.285.9426</p> <p>BCBSMT: 888.723.7443</p> <p>BCBSNM: 800.544.1378</p> <p>BCBSOK: 800.991.5643</p> <p>BCBSTX: 800.289.1525</p>		<p>Fax: 877.243.6930</p>	