ACA PREVENTION COPAY WAIVER
COPAY WAIVER 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 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 - 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? ☐ Yes ☐ No
2. Is the requested agent medically necessary? ☐ Yes ☐ No

For aspirin requests:

3. Is the patient pregnant, at high risk of preeclampsia, and using the requested agent after 12 weeks of gestation? ☐ Yes ☐ No

For bowel prep requests:

4. Will the requested agent be used for the preparation of colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy? ☐ Yes ☐ No

For breast cancer prevention requests:

5. Is the requested breast cancer primary prevention agent medically necessary? ☐ Yes ☐ No
6. Is the agent requested for the primary prevention of breast cancer? ☐ Yes ☐ No

For folic acid requests:

7. Does the requested folic acid supplement contain 0.4-0.8 mg of folic acid? ☐ Yes ☐ No
8. Is the requested folic acid supplement to be used in support of pregnancy? ☐ Yes ☐ No

For HIV infection: pre-exposure prophylaxis (PrEP) requests:

9. Is the requested agent being used for PrEP? ☐ Yes ☐ No
10. Does the patient have increased risk for HIV infection? ☐ Yes ☐ No
11. Has the patient recently tested negative for HIV? ☐ Yes ☐ No

For infant eye ointment requests:

12. Is the requested agent requested for the prevention of gonococcal ophthalmia neonatorum? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For iron supplement requests:

13. Is the patient at increased risk for iron deficiency anemia? ☐ Yes ☐ No

For statin requests:

14. Is the requested statin for use in the primary prevention of cardiovascular disease (CVD)? ☐ Yes ☐ No
15. Does the patient have at least one of the following risk factors: 1) dyslipidemia, 2) diabetes, 3) hypertension, or 4) smoking? ☐ Yes ☐ No
16. Does the patient have a calculated 10-year risk of a cardiovascular event of 10% or greater per the American College of Cardiology and American Heart Association's Atherosclerotic Cardiovascular Disease (ASCVD) calculator? ☐ Yes ☐ No

For tobacco cessation:

17. Is the patient a non-pregnant adult? ☐ Yes ☐ No

For vaccines:

18. Will the requested vaccine be used per the recommendations of the Advisory Committee on Immunization Practices/CDC? ☐ 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