QUANTITY LIMIT REQUEST

PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.
By submitting this form, you attest that all information provided is true and accurate.

PLEASE NOTE: Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit www.myprime.com

PATIENT AND INSURANCE INFORMATION **Today's date:** _____

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):
Patient Street Address:	City, State:	ZIP:	Patient Phone:
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

MEDICAL INFORMATION. PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED.

Patient Diagnosis with ICD-9 Code:	ICD-10 Code:
Medication and Strength Requested:	
Dosing Schedule:	Quantity per Month:

ALL REQUESTS

Please list the medications the patient has previously tried and failed for the treatment of this diagnosis:

_____ Date range: _____ _____ Date range:_____
_____ Date range: _____ _____ Date range:_____
_____ Date range: _____ _____ Date range:_____

Is the patient currently treated with the requested agent?..... ☐ Yes ☐ No

If applicable, please specify the patient's current body surface area (BSA): _____(m^2)

If applicable, please specify the patient's current weight: _____ ☐ LBS ☐ KGS

Is the prescribed dose higher than the maximum dose recommended in FDA approved labeling (i.e., the package insert)?..... ☐ Yes ☐ No

If yes: Please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature.)

Please list all reasons for selecting the requested medication, 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):

_____
_____

Please list any other medications the patient will use in combination with the requested medication for treatment of this diagnosis.

_____
_____

Please continue to the next page.

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

For acute migraine 5HT agent:

Has the patient been evaluated for medication overuse headache? ☐ Yes ☐ No

If yes: Does the patient have medication overuse headaches? ☐ Yes ☐ No

For anticoagulant agents:

Will the requested agent be used for prophylaxis of DVT and PE following hip replacement surgery? ☐ Yes ☐ No

Will the requested agent be used for prophylaxis of DVT and PE following knee replacement surgery? ☐ Yes ☐ No

Will the requested agent be used for treatment of DVT/PE? ☐ Yes ☐ No

Will the requested agent be used to reduce the risk of recurrence of DVT/PE? ☐ Yes ☐ No

If yes: Has the patient completed initial treatment lasting at least 6 months? ☐ Yes ☐ No

Will the requested agent be used to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation? ☐ Yes ☐ No

Will the requested agent be used to reduce the risk major cardiovascular events (CV death, MI, and stroke) in chronic CAD or PAD? ☐ Yes ☐ No

Will the requested agent be used for prophylaxis of VTE and VTE-related death during hospitalization and post-hospital discharge in a patient admitted for an acute medical illness? ☐ Yes ☐ No

If yes: Is the patient at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE? ☐ Yes ☐ No

If yes: Is the patient at high risk of bleeding? ☐ Yes ☐ No

For antiemetic agent:

Please select the patient's diagnosis and answer all corresponding questions:

☐ Cancer chemotherapy related nausea and vomiting

Please provide the patient's chemotherapy regimen: _____

How many days per month is the patient receiving chemotherapy? _____

☐ Delayed emesis in highly emetogenic chemotherapy

☐ Radiation therapy induced nausea and vomiting

How many days per month is the patient receiving radiation? _____

☐ Hyperemesis gravidarum

☐ Other (Please specify): _____

For Cesamet (nabilone) requests:

Will the patient be using Cesamet in addition to the patient's current regimen for cancer chemotherapy related nausea and vomiting? ☐ Yes ☐ No

If currently treated with the requested medication: Did a prior health plan pay for the patient's medication during the 90 days immediately before this request? ☐ Yes ☐ No

For Lampit requests:

Does the patient have a re-infection? ☐ Yes ☐ No

Please indicate:

☐ Date of service (if applicable): (mm/dd/yyyy): _____

☐ Start of treatment: Start date (mm/dd/yyyy): _____

☐ Continuation of therapy: Date of last treatment (mm/dd/yyyy): _____

What is the priority level of this request?

☐ Standard

☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

If yes: Please specify: _____

_____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183