PRIOR AUTHORIZATION/STEP THERAPY 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:

If requesting insulin, please note that Novolin and Novolog are the preferred insulin products.

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 medication? ..... ☐ Yes ☐ No

If yes: Is the current use with samples? ..... ☐ Yes ☐ No

Did a prior health plan pay for the patient's medication during the 90 days immediately before this request? Please note: documentation of a health plan paid claim for the medication during the 90 days immediately before the request must be submitted..... ☐ Yes ☐ No

Is the patient at risk if they change therapy? ..... ☐ Yes ☐ No

If yes: Please explain: _____

_____

Does the patient have any FDA labeled contraindication(s) to the requested agent? ..... ☐ Yes ☐ No

If yes: Please provide contraindication(s):_____

_____

Please continue to the next page.

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

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 all other medications the patient is currently taking for treatment of this diagnosis. _____

_____

_____

_____

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