RAPID TO INTERMEDIATE ACTING INSULIN
PRIOR AUTHORIZATION 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 yes: Did a prior health plan pay for the patient's medication during the 90 days immediately before this request? ..... ☐ Yes ☐ No

Is the patient pregnant? ..... ☐ Yes ☐ No

Does that patient have a physical or a mental disability that would prevent him/her from using all preferred insulin agents? ..... ☐ Yes ☐ No

Please continue to the next page.

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

For non-preferred rapid insulin [i.e., Admelog (insulin lispro), Apidra (insulin glulisine), Insulin aspart, Insulin lispro] requests only: Is the patient currently using an insulin pump that has an incompatibility with all preferred rapid insulin agents that is not expected to occur with the requested agent? [Preferred rapid insulins: Fiasp (insulin aspart), Humalog (insulin lispro), Humalog U200 (insulin lispro),Lyumjev (insulin lispro-aabc), NovoLog (insulin aspart)] ☐ Yes ☐ No

If no: Has the patient tried and had an inadequate response to ALL preferred rapid insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No

If no: Does the patient have an intolerance or hypersensitivity to ALL preferred rapid insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No

If no: Does the patient have an FDA labeled contraindication to ALL preferred rapid insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No

For non-preferred regular insulin [i.e., Humulin R U-500(regular human insulin concentrated) and ReliOn R (regular human insulin)] requests only: Has the patient tried and had an inadequate response to ALL preferred regular insulin agents that is not expected to occur with the requested agent? [Preferred regular insulins: Humulin R U-100 (regular human insulin) and Novolin R (regular human insulin)] ☐ Yes ☐ No

If no: Does the patient have an intolerance or hypersensitivity to ALL preferred regular insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No

If no: Does the patient have an FDA labeled contraindication to ALL preferred regular insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No

For non-preferred mixed insulin [i.e., Insulin aspart protamine/insulin aspart Mix 70/30 and Insulin lispro protamine/insulin lispro 75/25] requests only: Has the patient tried and had an inadequate response to ALL preferred mixed insulin agents that is not expected to occur with the requested agent? [Preferred mixed insulin: Humalog 75/25 (75% insulin lispro protamine suspension/25% insulin lispro), Humalog 50/50 (50% insulin lispro protamine suspension/50% insulin lispro), Humulin 70/30 (70% human insulin isophane suspension/30% human insulin), Novolin 70/30 (70% human insulin isophane suspension/30% human insulin), NovoLog 70/30 (70% insulin aspart protamine/30% insulin aspart)] ☐ Yes ☐ No

If no: Does the patient have an intolerance or hypersensitivity to ALL preferred mixed insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No

If no: Does the patient have an FDA labeled contraindication to ALL preferred mixed insulin agents that is not expected to occur with the requested agent? ☐ Yes ☐ No

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 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 Suite 200
Eagan, MN 55121

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183

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