INSULIN COMBINATION
STEP THERAPY 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 being treated with the requested agent? ☐ Yes ☐ No
   - If yes, is the patient currently stable on the requested agent? ☐ Yes ☐ No
     - If no, has the patient been treated with the requested agent within the past 90 days? ☐ Yes ☐ No
       - If yes, is the patient currently stable on the requested agent? ☐ Yes ☐ No
2. Does the patient have a diagnosis of type 2 diabetes with/or at high risk for atherosclerotic cardiovascular disease, heart failure, and/or chronic kidney disease? ☐ Yes ☐ No
3. Is the requested agent medically necessary and appropriate for the patient? ☐ Yes ☐ No
4. Has the patient tried and had an inadequate response to a diabetic agent [i.e., agents containing metformin, agents containing insulin, agents containing DPP-4 inhibitors, agents containing SGLT2 inhibitors, sulfonylureas, dopamine receptor agonists-ergot derivatives (e.g., bromocriptine), d-phenylalanine derivatives, meglitinide analogues, alpha-glucosidase inhibitors, thiazolidinediones, sulfonylurea-thiazolidinedione combinations]? ☐ Yes ☐ No
   If yes, please specify agent: _____
5. Was a diabetic agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
   If yes, please specify agent: _____
6. Does the patient have a documented intolerance or hypersensitivity to a diabetic agent that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please explain intolerance/hypersensitivity: _____
   _____
7. Does the patient have an FDA labeled contraindication to ALL diabetic agents that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindication: _____
   _____

Please continue to the next page.

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

8. Is a diabetic agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ..... ☐ Yes ☐ No
9. Is a diabetic agent not in the best interest of the patient based on medical necessity? ..... ☐ Yes ☐ No
10. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as a diabetic agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ..... ☐ Yes ☐ No
    If yes, please specify drug: _____
11. 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): _____
    _____
    _____

Please fax or mail this form to:
Prime Therapeutics LLC
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Eagan, MN 55121

TOLL FREE

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BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
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