ALTERNATIVE DOSAGE FORM
PRIOR AUTHORIZATION 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? **Please note, chart notes are required.** ☐ Yes ☐ No
2. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindications: _____
   _____
3. Does the requested quantity (dose) exceed the maximum FDA labeled dose? ☐ Yes ☐ No
   If yes, please give rationale in support of therapy with a higher dose for the requested indication: _____
   _____
   _____
   If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength? ☐ Yes ☐ No
   If no, please explain: _____
   _____
4. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? ☐ Yes ☐ No
5. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.** ☐ Yes ☐ No
6. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? ☐ Yes ☐ No

Please continue to the next page.

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

Please submit chart notes to support the answers to the following questions:

7. Is the oral solid dosage form (prescription or OTC if applicable) not clinically appropriate for the patient (i.e., difficulty swallowing tablets/capsules; for sucralfate requests, unable to dissolve the tablet dosage form in water)? ☐ Yes ☐ No
8. Has the patient tried and had an inadequate response to the oral solid dosage form (prescription or OTC if applicable)? ☐ Yes ☐ No
9. Was the oral solid dosage form (prescription or OTC if applicable) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
10. Does the patient have an intolerance or hypersensitivity to the oral solid dosage form (prescription or OTC if applicable) that is not expected to occur with the requested agent? ☐ Yes ☐ No
11. Does the patient have an FDA labeled contraindication to the oral solid dosage form (prescription or OTC if applicable) that is not expected to occur with the requested agent? ☐ Yes ☐ No
12. Is the oral solid dosage form (prescription or OTC if applicable) 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
13. Is the oral solid dosage form (prescription or OTC if applicable) not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
14. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the oral solid dosage form (prescription or OTC if applicable) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ 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**
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