DRUGS AND BIOLOGICS WITHOUT MEDICAL COVERAGE GUIDELINES (MCGs)
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:
Place of Service:	Route of Administration:	Healthcare professional to administer? ☐ Yes ☐ No	Buy and Bill: ☐ Yes ☐ No

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

Has the requested product been approved by the United States Food and Drug Administration (FDA)? ..... ☐ Yes ☐ No

Is the patient diagnosed with a condition that is consistent with an indication listed in the product's FDA approved prescribing information (or package insert)? ..... ☐ Yes ☐ No

If no: Is the requested product designated as an orphan drug by the FDA for the requested indication (i.e., "Designated/Approved", "Designated")? (Orphan drug designations can be found at http://www.accessdata.fda.gov/scripts/opdlisting/oopd/) ..... ☐ Yes ☐ No

If yes: Are additional requirements listed in the "Indications and Usage" section of the FDA approved prescribing information (package insert)? ..... ☐ Yes ☐ No

If yes: Does the patient meet the additional requirements listed in the "Indications and Usage" section of the FDA approved prescribing information (package insert)? ..... ☐ 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 list all other medications the patient is currently taking for treatment of this diagnosis. _____

_____

Please continue to the next page.

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

Is the requested drug an oncology medication (including interferons for oncology use)? ..... ☐ Yes ☐ No

If yes: Is the indication AND usage of the requested product recognized in NCCN Drugs and Biologics Compendium as a Category 1 or 2A recommendation?..... ☐ Yes ☐ No

If yes: Please explain. _____

_____

If no: Is the indication AND usage of the requested product supported by the results of TWO or more published clinical studies? [NOTE: Case reports, posters, and abstracts (including published meeting abstracts) are not accepted as evidence to support for use. Clinical studies must be supportive of use for a similar patient population (e.g., indication, diagnosis, disease severity, genetic or tumor mutations) and for the intended treatment plan, including any concomitant therapy.]..... ☐ Yes ☐ No

If yes: Please note, full text copies of each article must be submitted for review..... ☐ Yes ☐ No

Is the indication AND usage of the requested product recognized in one or more of the standard reference compendium (AHFS-DI with supportive narrative text, NCCN Drugs and Biologics Compendium [Category Levels 1 and 2A], Thomson Micromedex DrugDex [Strength of recommendation: Class I (Recommended) or IIa (Recommended, In Most Cases) AND Efficacy: Class I (Effective) or IIa (Evidence favors Efficacy], or Clinical Pharmacology with supportive narrative text)? ..... ☐ Yes ☐ No

If no: Is the indication AND usage of the requested product supported by the results of TWO or more published clinical studies? [NOTE: Case reports, posters, and abstracts (including published meeting abstracts) are not accepted as evidence to support for use. Clinical studies must be supportive of use for a similar patient population (e.g., indication, diagnosis, disease severity, genetic or tumor mutations) and for the intended treatment plan, including any concomitant therapy.]..... ☐ Yes ☐ No

If yes: Please note, full text copies of each article must be submitted for review. ..... ☐ Yes ☐ No

Is the dose and frequency for the patient's indication supported by the standard reference compendium (AHFS-DI, NCCN Drugs and Biologics Compendium [Category Levels 1 & 2A], Thomson Micromedex DrugDex [Strength of recommendation: Class I (Recommended) or IIa (Recommended, In Most Cases) AND Efficacy: Class I (Effective) or IIa (Evidence favors Efficacy), or Clinical Pharmacology)? ..... ☐ Yes ☐ No

If no: Is the dose and frequency for the patient's indication supported by the results of TWO or more published clinical studies? [NOTE: dose ranging studies, case reports, posters, and abstracts (including published meeting abstracts) are not accepted as evidence to support use.] ..... ☐ Yes ☐ No

If yes: Please note, full text copies of each article must be submitted for review. ..... ☐ 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