COVERAGE EXCEPTION
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information please visit www.myprime.com.

What is the priority level of this request?

☐ Standard

☐ Date of service (if applicable): _____

☐ 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.)

PATIENT AND INSURANCE INFORMATION **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 #:	

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

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 and description):	
Patient's height:	Patient's weight:
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? ..... ☐ Yes ☐ No
   If yes, is the patient at risk if therapy is changed? ..... ☐ Yes ☐ No
   If yes, please explain risk: _____
   _____
2. Please list all reasons for selecting the requested medication, 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). _____
   _____
   _____
3. Please list any other medications the patient will use in combination with the requested medication for treatment of this diagnosis. _____
   _____
   _____
4. Is the requested agent medically necessary? ..... ☐ Yes ☐ No
   If yes, please provide supporting information: _____
   _____

Please continue to the next page.

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

5. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. Please specify if the patient has tried brand-name products, generic products or over-the-counter products.

_____ Date(s): _____ _____ Date(s): _____

_____ Date(s): _____ _____ Date(s): _____

_____ Date(s): _____ _____ Date(s): _____

6. Please provide information indicating the cause of the patient's failure to any previously tried treatments for this diagnosis.__

_____

_____

_____

For Aspirin Therapy:

7. Is the patient pregnant, at high risk of preeclampsia, and using the requested agent after 12 weeks gestation? ☐ Yes ☐ No

For Bowel Prep Therapy:

8. Will the requested agent be used for the preparation of colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy? ☐ Yes ☐ No

For Breast Cancer Primary Prevention Therapy:

9. Is the requested agent being requested for the primary prevention of breast cancer? ☐ Yes ☐ No
10. Is the patient female? ☐ Yes ☐ No

If no, is the requested agent medically appropriate for the patient's sex? ☐ Yes ☐ No

If yes, please explain: _____

_____

For Contraceptive Agents:

11. Is the requested agent being used for contraception? ☐ Yes ☐ No
12. Is the patient female? ☐ Yes ☐ No

If no, is the requested agent medically appropriate for the patient's sex? ☐ Yes ☐ No

If yes, please explain: _____

_____

For Folic Acid Therapy:

13. Is the requested agent being used to support pregnancy? ☐ Yes ☐ No
14. Is the patient female? ☐ Yes ☐ No

If no, is the requested agent medically appropriate for the patient's sex? ☐ Yes ☐ No

If yes, please explain: _____

_____

For HIV Infection PrEP Therapy:

15. Is the requested agent being used for PrEP? ☐ Yes ☐ No
16. Is the requested agent medically necessary? ☐ Yes ☐ No

If yes, please explain:_____

_____

17. Is the requested PrEP agent any of the following: tenofovir disoproxil fumarate and emtricitabine combination ingredient agent, tenofovir alafenamide and emtricitabine combination ingredient agent, or cabotegravir? ☐ Yes ☐ No
18. Does the patient have an increased risk for HIV infection? ☐ Yes ☐ No
19. Has the patient recently tested negative for HIV? ☐ Yes ☐ No

Please continue to the next page.

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

For Infant Eye Ointment Therapy:

20. Is the requested agent for the prevention of gonococcal ophthalmia neonatorum? ☐ Yes ☐ No

For Iron Supplements Therapy:

21. Is the patient at increased risk of iron deficiency anemia? ☐ Yes ☐ No

For Statin Therapy:

22. Is the requested agent for use in the primary prevention of cardiovascular disease (CVD)? ☐ Yes ☐ No
23. Does the patient have any of the following CVD risk factors? Check all that apply.
    - ☐ Dyslipidemia
    - ☐ Hypertension
    - ☐ Diabetes
    - ☐ Smoking
24. Does the patient have a calculated 10-year risk of a cardiovascular event of 10% or greater based on calculations from the ACA/AHA ASCVD Risk Estimator (https://tools.acc.org/ASCVD-Risk-Estimator/)? ☐ Yes ☐ No

For Tobacco Cessation Therapy:

25. Is the patient a non-pregnant adult? ☐ Yes ☐ No
26. Has the patient received 180 or more day supply of the requested tobacco cessation agent type (e.g., NRT, bupropion, varenicline) in the past 365 days? ☐ Yes ☐ No
    - If yes, is the patient currently being treated with the requested tobacco cessation agent type (e.g., NRT, bupropion, varenicline) and is expected to be successful on this course of therapy? ☐ Yes ☐ No
      - If yes, please explain: _____
    - If no, is there support for the anticipated success of repeating therapy with the requested tobacco cessation agent type (e.g., NRT, bupropion, varenicline)? ☐ Yes ☐ No
      - If yes, please provide supporting information: _____

For Vaccine Therapy:

27. Will the requested vaccine be used per the recommendations of the Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control (CDC)? ☐ 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:	**888.274.5158**	**Fax: 855.212.8110**
BCBSFL:	**888.271.3183**	**Fax: 855.212.8110**
BCBSNJ:	**888.214.1784**	**Fax: 855.212.8110**
BCBSRI:	**855.457.0759**	**Fax: 855.212.8110**
CHP:	**855.457.0754**	**Fax: 855.212.8110**