PRIOR AUTHORIZATION
STEP THERAPY
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):	
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, when was treatment with the requested medication started? ______________________
   If yes, was the patient started on samples? .... ☐ Yes ☐ No
   If yes, is the patient at risk if therapy is changed?............ ☐ Yes ☐ No
   If yes, please explain:____
   ____
2. Please list all other medications the patient will use in combination with the requested medication for the treatment of this diagnosis.____
   ____
   ____
3. 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 max). ____
   ____
   ____

Please continue to the next page.

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

4. 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): _________

For behavioral health diagnoses:

5. Please list all reasons for selecting the requested medication over alternatives (e.g., contraindications, risk with change, started on while in hospital, allergies or history of adverse drug reactions, lower dose). _______________________________________
    ____
    ____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE
Phone: 888.274.5158 Fax: 855.212.8110

CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.