Print Reset

Coverage Exception
Choice Prescriber Fax Form
Fax this form to 800-424-3260

Prime Therapeutics Management LLC partners with CoverMyMeds to allow for the submission of electronic PA requests. **For faster coverage determinations, go to www.CoverMyMeds.com.**

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 visit web.primetherapeutics.com/provider/forms or primetherapeutics.com/commercial-formularies.

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.)

Today's Date: _____

PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____

Patient ID: _____ Date of Birth: _____ Patient Phone: _____

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Height: _____ ☐ in. ☐ cm Weight: _____ ☐ lbs. ☐ kg

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Email: _____

Prescriber NPI: _____ DEA: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Patient's Name (Last, First): _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Number of Refills: _____ Day Supply: _____

☐ New Therapy ☐ Renewal If renewal, date therapy initiated: _____

If renewal, duration of therapy (specific dates): _____ to _____

CRITERIA FOR ALL REQUESTS

Note: Please attach any additional information that should be considered with this request.

Patient's Diagnosis:

ICD Code: _____

ICD Description: _____

1. Is the patient currently treated with the requested medication?

   ☐ Yes ☐ No

   If Yes, how did the patient receive the medication?

   ☐ Insurance (list name): _____

   ☐ Samples

   ☐ Other (please explain): _____

2. Has the patient been treated with the requested agent within the past 90 days?

   ☐ Yes ☐ No

   If Yes, is the patient at risk if therapy is changed?

   ☐ Yes ☐ No

   If Yes, explain:

   _____

3. Has the patient tried and had an inadequate response to at least **two** formulary alternatives (any formulary tier), if available, for the diagnosis being treated with the requested agent?

   ☐ Yes ☐ No

   If Yes, please list:

   _____

   If No, are **all** available formulary (any formulary tier) alternatives are contraindicated, likely to be less effective, or cause an adverse reaction or other harm for the patient?

   ☐ Yes ☐ No

   If Yes, please provide details:

   _____

Patient's Name (Last, First): _____

4. 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).

   _____

5. Please list any other medications that the patient will use in combination with the requested medication for treatment of this diagnosis.

   _____

6. Is the requested agent medically necessary?

   ☐ Yes ☐ No

   If Yes, please explain:

   _____

7. Please list all medications that the patient has previously tried and had an inadequate response, intolerance or contraindication to for the treatment of this diagnosis. Please specify whether the patient has tried brand-name products, generic products, or over-the-counter products.

   Medication: _____

   Outcome of trial: _____

   Date (from): _____ Date (to): _____

   Medication: _____

   Outcome of trial: _____

   Date (from): _____ Date (to): _____

   Medication: _____

   Outcome of trial: _____

   Date (from): _____ Date (to): _____

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

   _____

Patient's Name (Last, First): _____

CRITERIA FOR BRAND NAME PRODUCTS

9. Has the patient tried and had an inadequate response to one or more available formulary generic equivalent to the requested agent?

   ☐ Yes ☐ No

   If No, is there support that ALL available formulary (any formulary tier) generic equivalent to the requested agent are contraindicated, are likely to be less effective, or will cause an adverse reaction or other harm for the patient?

   ☐ Yes ☐ No

   If Yes, please provide support:

   _____

10. Does the requested medication have a formulary biosimilar agent available?

    ☐ Yes ☐ No

    If Yes, has the patient had an inadequate response to at least three (or as many as available, if fewer than three) of the available formulary biosimilar agent(s) with at least a 3-month trial of each?

    ☐ Yes ☐ No

    If Yes, please provide names of biosimilar and duration of each trial:

    _____

    If No, please provide support that **all** available formulary biosimilar agent(s) are contraindicated, likely to be less effective, or cause an adverse reaction or other harm for the patient that is **not** expected to occur with the requested agent:

    _____

CRITERIA FOR ASPIRIN THERAPY

11. Is the patient pregnant, at high risk of preeclampsia, and using the requested agent after 12 weeks gestation?

    ☐ Yes ☐ No

CRITERIA FOR BOWEL PREP THERAPY

12. Will the requested agent be used for the preparation of colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy?

    ☐ Yes ☐ No

Patient's Name (Last, First): _____

CRITERIA FOR BREAST CANCER PRIMARY PREVENTION THERAPY

13. Is the requested agent being requested for the primary prevention of breast cancer?
    ☐ 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:

    _____

CRITERIA FOR CONTRACEPTIVE AGENTS

15. Is the requested agent being used for contraception?
    ☐ Yes ☐ No

    If No, please explain use:

    _____

CRITERIA FOR FOLIC ACID THERAPY

16. Is the requested agent being used to support pregnancy?
    ☐ Yes ☐ No
17. 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:

    _____

Patient's Name (Last, First): _____

CRITERIA FOR HIV INFECTION PREP THERAPY

18. Is the requested agent being used for PrEP?
    ☐ Yes ☐ No
19. Is the requested agent medically necessary compared to other available PrEP agents?
    ☐ Yes ☐ No

    If Yes, please explain:

    _____
20. Is the requested PrEP agent any of the following?
    - Tenofovir disoproxil fumarate and emtricitabine combination-ingredient agent
    - Tenofovir alafenamide and emtricitabine combination-ingredient agent
    - Cabotegravir
    - Yeztugo (lenacapavir)

    ☐ Yes ☐ No
21. Is the patient at high risk of HIV infection?
    ☐ Yes ☐ No
22. Has the patient recently tested negative for HIV?
    ☐ Yes ☐ No

CRITERIA FOR INFANT EYE OINTMENT THERAPY

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

CRITERIA FOR IRON SUPPLEMENTS THERAPY

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

CRITERIA FOR STATIN THERAPY

25. Is the requested agent for use in the primary prevention of cardiovascular disease (CVD)?
    ☐ Yes ☐ No
26. Does the patient have any of the following CVD risk factors? **Select all that apply.**
    ☐ Dyslipidemia ☐ Diabetes ☐ Hypertension ☐ Smoking
27. 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

Patient's Name (Last, First): _____

CRITERIA FOR TOBACCO CESSATION THERAPY

28. Is the patient pregnant?
    ☐ Yes ☐ No
29. Has the patient received a supply of 180 days or more 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 the patient expected to be successful on this course of therapy?
    ☐ Yes ☐ No

    If Yes, please explain:

    _____

    If No, is there information supporting the anticipated success of repeating therapy with the requested tobacco cessation agent type (e.g., NRT, bupropion, varenicline)?
    ☐ Yes ☐ No

    If Yes, please explain:

    _____

CRITERIA FOR VACCINE THERAPY

30. Will the requested vaccine be used in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control (CDC)?
    ☐ Yes ☐ No

☐ Attachments

Patient's Name (Last, First): _____

ATTESTATION

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: _____ **Date:** _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Please fax or mail this form to:

Prime Therapeutics Management LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 1-800-424-3312

Fax this form to 800-424-3260

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