Print Reset

Quantity Limit
Choice Prior Authorization Request Prescriber Fax
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 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

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 being treated with the requested agent?

   ☐ Yes ☐ No

2. What is the patient's weight? _____

3. What is the patient's body surface area (BSA) in square meters (m^2)? _____

4. Does the requested dose exceed the maximum FDA labeled dose for the requested indication?

   ☐ Yes ☐ No

   If Yes, please provide support for therapy with a higher dose for the requested indication.

   _____

5. 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 maximum).

   _____

6. Please list all medications that the patient has previously tried and failed for treatment of this diagnosis. (Please specify whether the patient has tried brand-name products, generic products, or over-the-counter products.)

   Medication: _____ Type: _____

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

   Medication: _____ Type: _____

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

   Medication: _____ Type: _____

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

Patient's Name (Last, First): _____

CRITERIA FOR ANTICOAGULANT AGENTS

7. Has the patient been re-infected and requires an additional course of therapy?
   ☐ Yes ☐ No
8. Will the requested agent be used for prophylaxis of deep vein thrombosis (DVT) and pulmonary embolism (PE) following hip replacement surgery?
   ☐ Yes ☐ No
9. Will the requested agent be used for prophylaxis of DVT and PE following knee replacement surgery?
   ☐ Yes ☐ No
10. Will the requested agent be used for treatment of DVT/PE?
    ☐ Yes ☐ No
11. Will the requested agent be used to reduce the risk of recurrence of DVT/PE?
    ☐ Yes ☐ No

    If Yes, has the patient completed initial treatment lasting at least 6 months?
    ☐ Yes ☐ No
12. Will the requested agent be used to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation?
    ☐ Yes ☐ No
13. Will the requested agent be used to reduce the risk major cardiovascular (CV) events (i.e., CV death, myocardial infarction [MI], and stroke) in chronic coronary artery disease (CAD) or peripheral artery disease (PAD)?
    ☐ Yes ☐ No

CRITERIA FOR ANTIEMETIC AGENTS

14. Does the patient have cancer chemotherapy related nausea and vomiting?
    ☐ Yes ☐ No

    If Yes, how many days per month is the patient receiving chemotherapy? _____Days
15. Does the patient have delayed emesis in highly emetogenic chemotherapy?
    ☐ Yes ☐ No

    If Yes, how many days per month is the patient receiving chemotherapy? _____Days

    If Yes, will the requested agent be used in addition to the patient's current regimen?
    ☐ Yes ☐ No
16. Does the patient have a diagnosis of hyperemesis gravidarum?
    ☐ Yes ☐ No
17. Does the patient have radiation therapy induced nausea and vomiting that extends beyond 7 days per month?
    ☐ Yes ☐ No

Patient's Name (Last, First): _____

CRITERIA FOR SUBUTEX (BUPRENORPHINE SUBLINGUAL TABLETS)

18. Is the patient pregnant?
    ☐ Yes ☐ No
19. Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to naloxone or naltrexone?
    ☐ Yes ☐ No

    If Yes, please explain:

    _____

CRITERIA FOR LOW MOLECULAR WEIGHT HEPARINS (LMWH) AND ARIXTRA®

20. Does the patient require extended treatment for primary or secondary prophylaxis of thromboembolism during pregnancy and/or puerperium?
    ☐ Yes ☐ No
21. Does the patient have cancer and require extended prophylaxis and/or treatment of symptomatic VTE (proximal DVT and/or PE)?
    ☐ Yes ☐ No

CRITERIA FOR PROTON-PUMP INHIBITORS (PPI)

22. Does the patient have a hypersecretory disease (i.e., Zollinger-Ellison syndrome), Barrett's esophagitis, or esophageal stricture?
    ☐ Yes ☐ No
23. Has the patient failed conventional therapy (i.e., failure of standard labeled dosing with the requested agent)?
    ☐ Yes ☐ No
24. Is the patient requesting H. pylori treatment?
    ☐ 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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