Prior Authorization/Step Therapy
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 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: ______________

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

   ____

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 maximum).

   ____

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Patient's Name (Last, First): ______________________________

5. 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): ______________

CRITERIA FOR BEHAVIORAL HEALTH DIAGNOSES

6. 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).

   ____

☐ Attachments

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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