COPAY WAIVER
PRESCRIBER FAX FORM

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

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. To submit this form electronically, please go to covermymeds.com.

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's 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 Plus Description**:**	
Medication Requested:	Strength:
Dosing Schedule:	Quantity Per Month:

All Requests

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
2. Please list all reasons the requested medication, dosing schedule, and quantity are medically necessary for the patient (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): ______

Aspirin Therapy

3. Is the patient pregnant, at high risk of preeclampsia, and using the requested medication after 12 weeks of gestation? ☐ Yes ☐ No
4. Is the requested medication being used for the primary prevention of cardiovascular disease (CVD)? ☐ Yes ☐ No
   If yes, does the patient have a 10% or greater 10-year CVD risk? ☐ Yes ☐ No
5. Is the requested medication being used for the primary prevention of colorectal cancer (CRC)? ☐ Yes ☐ No
6. Is the patient able and willing to take a low-dose aspirin daily for at least 10 years? ☐ Yes ☐ No
7. Is the patient at an increased risk for bleeding? ☐ Yes ☐ No

Bowel Prep Therapy

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

Breast Cancer Prevention Therapy

9. Is the requested medication being used for the primary prevention of breast cancer? ☐ Yes ☐ No
10. Does the patient's medication history include the use of a generic equivalent prerequisite (e.g., generic raloxifene for brand Evista; generic tamoxifen for brand Soltamox)? ☐ Yes ☐ No
    If no, does the patient have a documented intolerance, FDA labeled contraindication, or hypersensitivity to the generic equivalent prerequisite? ☐ Yes ☐ No
    If yes, please explain: ______
11. Is the patient's sex female? ☐ Yes ☐ No
    If no, please explain why the requested medication is medically appropriate for the patient's sex: ______

Please continue to the next page.

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

Contraceptive Therapy

12. Is the requested agent being prescribed for contraception? ☐ Yes ☐ No
13. Is the requested contraceptive agent medically necessary? ☐ Yes ☐ No

Folic Acid Therapy

14. Will the requested folic acid supplement be used in support of pregnancy? ☐ Yes ☐ No
15. Is the patient's sex female? ☐ Yes ☐ No
    If no, please explain why the requested medication is medically appropriate for the patient's sex: ____________________

HIV Infection PrEP

16. Is the patient at high risk of HIV infection? ☐ Yes ☐ No
17. Has the patient recently tested negative for HIV? ☐ Yes ☐ No
18. Is the requested medication either of the following? ☐ Yes ☐ No
    - ☐ Tenofovir disoproxil fumarate and emtricitabine combination ingredient medication
    - ☐ Tenofovir disoproxil fumarate single ingredient medication

    If no, is tenofovir disoproxil fumarate and emtricitabine combination ingredient medication or tenofovir disoproxil fumarate single ingredient medication contraindicated, likely to be less effective, or cause an adverse reaction or other harm to the patient that is not expected to occur with the requested medication? ☐ Yes ☐ No

    If yes, please explain: ____________________

Infant Eye Ointment

19. Will the requested medication be used for the prevention of gonococcal ophthalmia neonatorum? ☐ Yes ☐ No

Iron Supplement Therapy

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

Statin Therapy

21. Will the requested medication be used in the primary prevention of cardiovascular disease (CVD)? ☐ Yes ☐ No
22. Does the patient have any of the following CVD risk factors? Please select all that apply. ☐ Yes ☐ No
    - ☐ Dyslipidemia
    - ☐ Diabetes
    - ☐ Hypertension
    - ☐ Smoking
23. Does the patient have a calculated 10-year risk of a cardiovascular event of 10% or greater per the American College of Cardiology and American Heart Association's Atherosclerotic Cardiovascular Disease (ASCVD) calculator? ☐ Yes ☐ No

Tobacco Cessation

24. Is the patient a non-pregnant adult? ☐ Yes ☐ No
25. Has the patient received more than a 180-day supply of the requested tobacco cessation medication type (e.g., NRT, bupropion, varenicline) in the past 365 days? ☐ Yes ☐ No

    If yes, is the patient currently treated with the requested tobacco cessation medication type? ☐ Yes ☐ No

    If yes, is there information that the patient is successful on this course of therapy but will exceed the allowed 24 weeks of therapy to finish this course? ☐ Yes ☐ No

    If yes, please explain: ____________________

    If no, is success anticipated for repeating therapy with the requested tobacco cessation medication type (e.g., NRT, bupropion, varenicline)? ☐ Yes ☐ No

    If yes, please explain: ____________________

Vaccine Therapy

26. Will the requested vaccine be used per the recommendations of the Advisory Committee on immunization Practices/CDC? ☐ Yes ☐ No

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

TOLL FREE

Fax: 855.212.8110 Phone: 855.457.0759

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