CONTRACEPTIVE 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 #:	

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