COVERAGE EXCEPTION
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:

1. Is the patient currently treated with the requested medication? ..... ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
   Is the patient at risk if change in therapy (current use with samples is not allowed)? ..... ☐ Yes ☐ No
2. Please list all reasons for selecting the requested medication and dose over alternatives (e.g. contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, risk with therapy change). _____

   _____

   _____

   Note: if the patient has experienced an intolerance to an interchangeable product, please complete and submit the Medwatch reporting form (FDA 3500) available at https://www.fda.gov/safety/medical-product-safety-information/forms-reporting-fda**. This form is required for review.**
3. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. Please specify if the patient has tried brand-name products, generic products, or over-the-counter products.

   _____ Date(s):_____ _____ Date(s): _____
   _____ Date(s):_____ _____ Date(s): _____
   _____ Date(s):_____ _____ Date(s): _____
4. Is the use of the target medication for an indication that is supported by compendia [NCCN Compendium (level of evidence 1, 2A)], AHFS, DrugDex (FDA approved Class I or Class IIa)]? ..... ☐ Yes ☐ No
   If yes, please specify:_____
   If no, is the requested use supported by clinical research in 2 or more peer reviewed medical journals? ..... ☐ Yes ☐ No
   Please submit supporting clinical documentation.
5. Is the requested dose supported by compendia [NCCN Compendium (level of evidence 1, 2A), AHFS, DrugDex (FDA approved Class I or Class IIa)]?..... ☐ Yes ☐ No
   If yes, please specify: _____
   If no, is the dose supported by clinical research in 2 or more peer reviewed medical journals? ..... ☐ Yes ☐ No
   Please submit supporting clinical documentation.

Please continue to the next page.

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

For contraceptive requests:

6. Is the requested agent being prescribed for contraception? ☐ Yes ☐ No
7. 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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