

COPAY WAIVER PHYSICIAN FAX FORM

This form is for prospective, concurrent, and retrospective reviews.

PLEASE NOTE: Incomplete forms will be returned for additional information.

PATIENT INFORMATION

Today's Date: _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:		City, State, Zip:	Patient Telephone:

INSURANCE INFORMATION

BCBS ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician 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: _____
For ALL Requests:	
1. Is the patient currently treated with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested medication started? _____	
2. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): _____ _____	
3. Please list all other medications the patient is currently taking for treatment of this diagnosis. _____ _____	
4. 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: _____ Date: _____ _____ Date: _____ Date: _____ _____ Date: _____ Date: _____	

For Breast Cancer Prevention Therapy:

5. Is the medication being requested for the prevention of breast cancer?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does the patient have a prior diagnosis of breast cancer?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 1305 Corporate Center Drive
 Eagan, Minnesota 55121

TOLL FREE
Fax: 877.480.8130 Phone: 866.202.3474

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