

**QUANTITY LIMIT
PHYSICIAN FAX FORM**



ONLY the prescriber may complete this form.

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Patient Telephone Number:
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HEALTH PLAN INFORMATION

Blue Cross 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-9 code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<p>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? _____</p> <p>2. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions.) _____ _____</p> <p>3. Please list all reasons for selecting the requested strength, dosing schedule and quantity over alternatives (e.g. lower dose has been tried.) _____ _____</p> <p>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 or generic products.) _____ _____</p> <p>5. Please list any other medications the patient will use in combination with the requested medication for treatment of this diagnosis. _____ _____</p>	

If the requested medication is a triptan (such as Imitrex):

6. Has the patient been evaluated for chronic daily headache caused by medication overuse? Yes 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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