

**STEP THERAPY AUTHORIZATION
PHYSICIAN FAX FORM**



ONLY the prescriber may complete this form.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information.

Today's Date: _____

PATIENT INFORMATION

| | | | | |
|-----------------------|-------|----|-----------------|---------------------------|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yy): | Patient Telephone Number: |
|-----------------------|-------|----|-----------------|---------------------------|

HEALTH PLAN INFORMATION

| | |
|--------------------|---------------|
| CCS tpa ID Number: | Group Number: |
|--------------------|---------------|

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: |
| Medication Requested: |
| <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 other medications the patient is currently taking for treatment of this diagnosis. _____ _____</p> <p>4. Please list any other 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.) _____ _____</p> |
| <p>If the requested medication is a Cox-2 inhibitor (such as Celebrex) Is the patient currently taking:</p> <p>1. Systemic corticosteroids on a regular basis (e.g. long-term daily or pulse therapy)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. An anticoagulant (e.g. warfarin?) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>If the requested medication is statin (such as Lipitor) please provide:</p> <p>1. Patient's baseline (pretreatment) fasting lipid panel: Total Cholesterol _____ TRI _____ HDL _____ LDL _____</p> <p>2. Patient's goal LDL _____ OR goal % LDL reduction _____</p> |

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

TOLL FREE

Fax: 877.480.8130 Phone: 866.202.3474

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