MEDICARE PART D PRESCRIPTION DRUG AUTHORIZATION REQUEST FORM

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

STANDARD REQUEST
EXPEDITED REQUEST

Prior Authorization Step Therapy Exception Request Non-formulary Drug Request for Tiering Exception
Request for Quantity Limit Exception Appeal

Patient Name			Date of Birth (mm/dd/yyyy)
Patient's Home Address			Contract Number (Include Prefix)
City	State	Zip	
Patient Phone Number			

Physician Name			Practice Type: PCP Specialist
Practice Address			Physician UPIN
City	State	Zip	Provider Number
Office Phone	Office Fax		

Drug Requested:	Dose Requested:
Reason for Use:	
ICD-9 Related to Use:	Duration of Disease:

List other medication this patient has tried with this condition:

Drug:	Regimen:	Dates of Therapy:	to
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Does this patient have any co-morbid conditions that will affect therapy: Yes No

If so, please list:

I certify this information is correct. I understand that intentional misrepresentation of information herein may constitute fraud and be subject to legal action.

Recertification is required annually. Physician Signature Date

BlueRx (PDP) is a Medicare Approved Part D Plan offered by Blue Cross and Blue Shield of Alabama and UTIC Insurance Company, independent licensees of the Blue Cross and Blue Shield Association. Prime Therapeutics, an independent company, manages pharmacy benefits for BlueRx (PDP) members on behalf of Blue Cross and Blue Shield of Alabama and UTIC Insurance Company.

SUBMISSION INSTRUCTIONS:

You may fax the signed and completed form to Clinical Review Dept. at:
1-800-693-6703

You may mail the signed and completed form to:
Prime Therapeutics LLC
Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

S1030_PDZ_052_15 Accepted