

MEDICARE PART D FORMULARY EXCEPTION INFORMATION

Please fax or mail the attached form to:

TOLL FREE

Fax: 800-693-6703 Phone: 800-693-6651

Prime Therapeutics LLC

Attn: Medicare Appeals Department

1305 Corporate Center Drive

Eagan, MN 55121

Please read all instructions below before completing the attached form.

- Please complete the attached Request for Coverage of a Non-Formulary Drug (Formulary Exception Form)
- To prevent delays in the review process please complete all requested fields.
- Completed forms should be faxed to: **800-693-6703**. It is not necessary to fax this cover page.

Information about this Request for Coverage of a Non-Formulary Drug (Formulary Exception)

Use this form to request coverage of a drug that is not on the member's formulary.

*To view a list of the available formulary alternatives, visit www.myprime.com and search for the patient's appropriate Medicare health plan.

To process this request, documentation that all formulary alternatives have been previously tried, would not be as effective or would have adverse effects is required. Please provide clinical information or other evidence supporting the medical necessity of the non-formulary drug.

You can expedite this request by indicating its urgency at the top of the attached form. If you request an expedited review and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously harm the member's life, health, or ability to regain maximum function.

CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and contains information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 800-858-0723, and return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.

MEDICARE PART D FORMULARY EXCEPTION PHYSICIAN FAX FORM



ONLY the prescriber may complete this form. This form is for Medicare Part D prospective, concurrent, and retrospective reviews.

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The following documentation is **REQUIRED**. For formulary information, please visit www.myprime.com and search for the appropriate health plan formulary. To submit this form electronically, please click [here](#) or go to covermy meds.com.

Per CMS requirements – all standard requests are completed within 72 hours (including weekends)

If you request an expedited review and sign this form, you certify that applying the 72 hour standard review time frame could seriously harm the patient's life, health or ability to regain maximum function. Please check the box to request an expedited review:

PATIENT, INSURANCE and PHYSICIAN/CLINIC INFORMATION

Today's Date: _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Insurance ID Number:		Patient Telephone Number:	
Prescribing Physician's Name:	Physician NPI#:	Specialty:	Clinic Contact Person's Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Clinic Phone #:	Clinic Secure Fax #:
Is the patient a long term care facility resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the LTC facility contact's name, telephone and fax numbers			
LTC Contact Name:		LTC Phone #:	LTC Secure Fax #:

Medication Requested: _____ Strength: _____

Dosing Schedule: _____ Quantity per Month: _____

Please list **ALL** diagnoses associated with use of medication. *To be eligible for coverage, drug must be prescribed for a medically accepted indication as defined by Medicare law.

- Diagnosis – ICD code plus description: _____
- Diagnosis – ICD code plus description: _____
- Diagnosis – ICD code plus description: _____

Is the patient currently treated with the requested medication (i.e this request is for a refill)?..... Yes No
 List **ALL** previously attempted drugs and indicate any adverse effects requiring discontinuation. Please provide dates of use.

- 1. _____ 2. _____ 3. _____ 4. _____

If no available formulary alternatives have been previously tried, please check this box:

Medical Justification: Please provide medical justification for the non-formulary drug exception request. Please address why **ALL** formulary alternatives on any tier of the formulary for treatment of the same condition not yet attempted would not be as effective or would cause adverse effects.

If all formulary agents would not be as effective or would have adverse effects, please provide clinical rationale for perceived ineffectiveness or adverse effects for **each** alternative: _____

* For formulary information, please visit www.myprime.com and search for the appropriate health plan formulary.

I attest that the information provided on this form is true and accurate as of this date:

Prescriber's signature: _____ **Date:** _____

Blue Advantage (PPO) is a Medicare-approved PPO plan. Enrollment in Blue Advantage (PPO) depends on CMS contract renewal. Blue Advantage (PPO) is provided by Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.