COVERAGE EXCEPTION
PRESCRIBER FAX FORM

ONLY the prescriber or clinic personnel may complete this form. This form is for prospective, concurrent, and retrospective reviews

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross Blue Shield of North Dakota web site at *www.bcbsnd.com*.

What is the priority level of this request?

☐ Standard review

☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

PATIENT AND INSURANCE INFORMATION **Today's date:**_____

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

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber 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:

1. Is the patient currently treated with the requested agent?..... ☐ Yes ☐ No

   If yes, is the patient at risk if the therapy is changed? ..... ☐ Yes ☐ No

   If yes, please explain:_____

   _____

2. 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.)

   a) Medication: _____

      Reason for failure: _____

   b) Medication: _____

      Reason for failure: _____

   c) Medication: _____

      Reason for failure: _____

   d) Medication: _____

      Reason for failure: _____

   e) Medication: _____

      Reason for failure: _____

3. Are all available alternatives contraindicated, likely to be less effective, or cause an adverse reaction or other harm for the patient? ..... ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

If yes, please explain: _____

_____

For contraceptive agents:

4. Is the requested contraceptive agent medically necessary? ☐ Yes ☐ No
5. Is the requested agent being used for contraception? ☐ Yes ☐ No

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE
Fax: 855.212.8110

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