Alliant Health

Prescription Drug Prior Authorization Form

Fax this form to 1-800-424-4054 **A fax cover sheet is not required.**

Prime Therapeutics Management LLC partners with CoverMyMeds to allow for the submission of electronic PA requests.
For faster coverage determinations, go to www.CoverMyMeds.com.

Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). Information contained in this form is Protected Health Information under HIPAA.

Date of Request: ______________________ ☐ **Non-Urgent** ☐ **Exigent Circumstances**

MEMBER INFORMATION

Member's Last Name: ______________________

Member's First Name: ______________________

Member's ID: ____________ Date of Birth: ____________ Member's Phone: ____________

Member's Street Address: ______________________

City: ______________________ State: ________ Zip: ____________

Sex: ☐ Male ☐ Female Height: ________ ☐ in. ☐ cm Weight: ________ ☐ lbs. ☐ kg

Allergies: ______________________

If you are not the member or prescriber, please submit a PHI Disclosure Authorization form with this request, located at Primetherapeutics.com/patientforms.

PRESCRIBER INFORMATION

Prescriber's Last Name: ______________________

Prescriber's First Name: ______________________

Specialty: ______________________ Email: ______________________

Prescriber's NPI: ______________________ DEA #: ______________________

Prescriber's Phone: ______________________ Prescriber's Fax: ______________________

Prescriber's Street Address: ______________________

City: ______________________ State: ________ Zip: ____________

DRUG INFORMATION

Drug Name: ______________________ Drug Form: ____________

Drug Strength: ______________________ Dosing Frequency: ______________________

Length of Therapy: ______________________ Quantity: ______________________

Number of Refills: ______________________ Day Supply: ______________________

☐ New Therapy ☐ Renewal If renewal, date therapy initiated: ______________________

If renewal, duration of therapy (specific dates): ______________________ to ______________________

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Member's Full Name: ____________________

DISPENSING INFORMATION

How did the member receive the medication?

☐ Paid Under Insurance

Prior Authorization # (if known): ____________________

Insurance Name: ____________________

☐ Other (explain): ____________________

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other: ____________________

Administration Location:

☐ Member's Home ☐ Long-Term Care ☐ Physician's Office

☐ Home Care Agency ☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care

☐ Other (explain): ____________________

DIAGNOSIS AND MEDICAL INFORMATION

1. Has the member tried any other medications for this condition?

   ☐ Yes ☐ No

   a. If Yes, what was the medication therapy (specify drug name and dosage)?

   b. What was the duration of therapy? Specify dates: ______________ to ______________

   c. What was the response, reason for failure, or allergy?

2. What are the member's diagnoses and ICD-10 codes?

   Diagnoses: ____________________

   ICD-10 codes: ____________________

Member’s Full Name: ____________________

3. **What additional clinical information do you have that is relevant to this request for a prior authorization?** Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if the member has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber’s Signature: ____________________ **Date:** ____________________

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Mail requests to:

Prime Therapeutics Management LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 1-800-424-1799

Fax this form to 800-424-4054.