

**QUANTITY LIMIT
PHYSICIAN FAX FORM**



ONLY the prescriber may complete this form.

The following documentation is **REQUIRED** for authorization. Incomplete forms will be returned for additional information. For formulary information, please visit the PrimeWest Health web site at www.primewest.org.

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	Patient's Telephone #:	DOB (mm/dd/yy):
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HEALTH PLAN INFORMATION

Member's Insurance ID Number:	Member's Insurance Group Number:
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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:	
Dosing Schedule	Quantity per Month
<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 reasons for selecting the requested strength, dosing schedule and quantity over alternatives (e.g. lower dose has been tried.) _____ _____</p> <p>4. 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 or generic products.) _____ _____</p> <p>5. Please list any other medications the patient will use in combination with the requested medication for treatment of this diagnosis. _____ _____</p>	
<p>If the requested medication is a triptan (such as Imitrex):</p> <p>6. Has the patient been evaluated for chronic daily headache caused by medication overuse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 **Phone:** 800.711.9866

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