2010 MEDICARE PART D
ALDARA®
PHYSICIAN FAX FORM

ONLY the prescriber may complete this form. This form is for Medicare Part D requests.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information, please visit www.myrxassistant.com and search for the appropriate health plan formulary.

Today's Date: ______________________

PATIENT, INSURANCE and PHYSICIAN/CLINIC INFORMATION

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? ☐ Yes ☐ No If yes, please provide the LTC facility contact's name, telephone and fax numbers			
LTC Contact Name:	LTC Phone #:	LTC Secure Fax #:	

DIAGNOSIS ICD-9 code plus description**:**

MEDICATION REQUESTED:	**Dosing Schedule:**
Quantity per Month:	**Expected duration of treatment:**

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

   If yes: -When was treatment with the requested medication started? ______________________

   -Is the patient currently taking a lower dose of the requested medication? (this request is for a higher dose) ☐ Yes ☐ No

2. Please list all reasons for selecting the requested **medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) ______________________

3. 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.) ______________________

4. Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. ______________________

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE

Fax: 800.693.6703 **Phone:** 800.693.6651

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