2010 MEDICARE PART D BIOLOGIC AGENTS
(Amevive®, Cimzia®, Enbrel®, Humira®, Kineret®, Orencia®, Remicade®, Rituxan®, Tysabri®)
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: **Strength:**

Dosing Schedule: **Quantity per Month:**

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

   If yes, when was treatment with the requested medication started? ____________________________

2. If the patient is currently prescribed the requested medication, has the treatment been beneficial in achieving remission of the disease or decreasing symptom severity? .... ☐ Yes ☐ No

3. For renewal of Amevive, has there been a minimum of 12 weeks since the end of the previous course of Amevive? .... ☐ Yes ☐ No

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

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5. 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.)____________________________

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6. If the patient has been previously treated with another biologic (Amevive, Cimzia, Enbrel, Humira, Kineret, Orencia, Remicade, Rituxan or Tysabri) will this drug be discontinued before the requested medication is started?.. ☐ Yes ☐ No

7. Please include any additional information that should be considered with this review. ____________________________

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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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