

**2010 MEDICARE PART D
FORMULARY OR TIER EXCEPTION
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> 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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