

**2010 MEDICARE PART D
QUANTITY LIMIT
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:

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

- Please list all reasons for selecting the requested **strength, dosing schedule and quantity** over alternatives (e.g. lower dose has been tried.) _____

- 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.) _____

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

If the requested medication is a triptan (such as Imitrex):

6. Has the patient been evaluated for chronic daily headache caused by medication overuse?..... Yes No

If the requested medication is a low molecular weight heparin (such as Lovenox):

7. Has the patient tried and failed Coumadin (warfarin)? Yes No

If no, please explain the reason _____

If the requested medication is Chantix:

8. Does the prescriber anticipate success of repeating therapy with Chantix/venenicline? Yes No

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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