AFFORDABLE CARE ACT (ACA) COPAY WAIVER
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber or clinic personnel may complete this form. This form is for prospective, concurrent, and retrospective reviews

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross Blue Shield of North Dakota web site at *www.bcbsnd.com*.

What is the priority level of this request?

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

PATIENT AND INSURANCE INFORMATION **Today's date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber 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 diagnosis (ICD code and description)**:**	
Medication requested:	Strength:
Dosing schedule:	Quantity per month:

All requests:

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

Aspirin requests:

2. Is the requested aspirin agent medically necessary? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
3. If the patient is pregnant, is the patient at high risk of preeclampsia and using the requested agent after 12 weeks gestation? ☐ Yes ☐ No

Bowel prep agent requests:

4. Is the requested bowel prep agent medically necessary? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
5. Will the requested agent be used for the preparation of colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy? ☐ Yes ☐ No

Breast cancer primary prevention agents:

6. Is the requested breast cancer primary prevention agent medically necessary? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

7. Is the requested agent being requested for the primary prevention of breast cancer? ☐ Yes ☐ No

Contraceptives requests:

8. Is the requested agent being used for contraception? ☐ Yes ☐ No

Is the requested contraceptive agent medically necessary? ☐ Yes ☐ No

Fluoride supplement requests:

9. Is the requested fluoride supplement medically necessary? ☐ Yes ☐ No

If yes, please explain: _____

_____

Folic acid supplement requests:

10. Is the requested folic acid supplement medically necessary? ☐ Yes ☐ No

If yes, please explain: _____

_____

11. Is the requested agent being used to support pregnancy? ☐ Yes ☐ No

HIV infection pre-exposure prophylaxis (PrEP) requests:

12. Is the requested agent being used for PrEP? ☐ Yes ☐ No

13. Is the requested PrEP agent medically necessary compared to other available PrEP agents? ☐ Yes ☐ No

If yes, please explain: _____

_____

14. Is the requested PrEP agent one of the following: tenofovir disoproxil fumarate and emtricitabine combination ingredient agent, tenofovir alafenamide and emtricitabine combination ingredient agent, or Cabotegravir? ☐ Yes ☐ No

If no, are any of the above agents contraindicated, likely to be less effective, or cause an adverse reaction or other harm to the patient? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

15. Is the patient at high risk of HIV infection? ☐ Yes ☐ No

16. Has the patient recently tested negative for HIV? ☐ Yes ☐ No

Iron supplements requests:

17. Is the requested iron supplement medically necessary? ☐ Yes ☐ No

If yes, please explain: _____

_____

18. Is the patient at increased risk for iron deficiency anemia? ☐ Yes ☐ No

Statins requests:

19. Is the requested statin medically necessary? ☐ Yes ☐ No

If yes, please explain: _____

_____

20. Is the requested statin for use in the primary prevention of cardiovascular disease (CVD)? ☐ Yes ☐ No

21. Does the patient have at least one of the following risk factors: dyslipidemia, diabetes, hypertension, or smoking? ☐ Yes ☐ No

22. Does the patient have a calculated 10-year risk of a cardiovascular event of 10% or greater based on calculations from the ACA/AHA ASCVD Risk Estimator (https://tools.acc.org/ASCVD-Risk-Estimator/)? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

Tobacco cessation agent requests:

23. Is the patient a non-pregnant adult? ☐ Yes ☐ No

24. Is the requested tobacco cessation agent medically necessary? ☐ Yes ☐ No

    If yes, please explain: _____

    _____

25. Has the patient received 180 or more days supply of the requested tobacco cessation agent type (e.g., NRT, bupropion, varenicline) within the past 365 days? ☐ Yes ☐ No

    If yes, is the patient currently treated with the requested agent and is expected to be successful on this course of therapy? ☐ Yes ☐ No

    If yes, please explain why patient is expected to be successful on this course of therapy: _____

    _____

    If yes, how many weeks of treatment has the patient completed? _____ weeks

    If no, is there information to support the anticipated success of repeating therapy with the requested agent? ☐ Yes ☐ No

    If yes, please explain: _____

    _____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
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Eagan, MN 55121

TOLL FREE
Fax: 855.212.8110

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