

**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?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Aspirin requests:	
2. Is the requested aspirin agent medically necessary?..... <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bowel prep agent requests:	
4. Is the requested bowel prep agent medically necessary?..... <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Breast cancer primary prevention agents:	
6. Is the requested breast cancer primary prevention agent medically necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy)
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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 disoproxil fumarate single ingredient agent, or tenofovir alafenamide and emtricitabine combination ingredient agent? ☐ 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):
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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 2900 Ames Crossing Road Eagan, MN 55121 TOLL FREE Fax: 855.212.8110	CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.
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