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.

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
2. Is the requested agent medically necessary? ☐ Yes ☐ No

   If yes, please explain: ____

   ____

   ____

Aspirin requests:

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
4. Is the requested agent being used for the primary prevention of cardiovascular disease (CVD)? ☐ Yes ☐ No

   If yes, does the patient have a 10% or greater 10-year CVD risk? ☐ Yes ☐ No
5. Is the requested agent being used for the primary prevention of colorectal cancer (CRC)? ☐ Yes ☐ No
6. Is the patient able and willing to take a low-dose aspirin daily for at least 10 years? ☐ Yes ☐ No
7. Is the patient at an increased risk for bleeding? ☐ Yes ☐ No

Bowel prep agents requests:

8. 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:

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

Please continue to the next page.

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

Contraceptives requests:

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

Folic acid supplement requests:

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 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: ______________________________

14. Is the patient at high risk of HIV infection? ☐ Yes ☐ No
15. Has the patient recently tested negative for HIV? ☐ Yes ☐ No

Iron supplements requests:

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

Statins requests:

17. Is the requested statin for use in the primary prevention of cardiovascular disease (CVD)? ☐ Yes ☐ No
18. Does the patient have at least one of the following risk factors: dyslipidemia, diabetes, hypertension, or smoking? ☐ Yes ☐ No
19. 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

Tobacco cessation agent requests:

20. Is the patient a non-pregnant adult? ☐ Yes ☐ No
21. 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, 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

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