STEP THERAPYPHYSICIAN FAX FORM



ONLY the prescriber or clinic personnel may complete this form.

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

			Today's Date:								
	ENT INFORMATION	_					ı				
Patient Name (First): Last:						M:	DOB (mm/dd/yyyy):				
Patient Address: City, State, Zip							Patient Telephone:				
INSUI	RANCE INFORMATION	•									
BCBS ID Number:					Group Number:						
PHYS	SICIAN/CLINIC INFORMATION	ON									
Prescriber Name: Physical Clinic Name:			Physician NPI#:	Specia			ialty:		Contact Name:		
Clinic	c Name:		Clinic A		Address:	\ddress:					
City, State, Zip:				Phone #:			Secure Fax #:				
PLEA	SE ATTACH ANY ADDITIO	NAL INF	FORMATION THAT	SHOU	LD BE CO	NSIDERE	D WIT	TH THIS	REQUEST		
	ent's Diagnosis - ICD-9 code										
Medication Requested:					Strength:						
Dosing Schedule:					Quantity per Month:						
1.	Is the patient currently treated with the requested medication?										
	If yes, when was treatment with the requested medication started?										
2.	Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of										
		rug reactions to alternatives.)									
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•											
3.	B. Please list all other medications the patient is currently taking for treatment of this diagnosis.										
4.	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.)										
Pleas	se fax or mail this form to:			CONF	IDENTIALIT	Y NOTICE	: This	message	e is intended only for the individua		
Prime Therapeutics LLC, Clinical Review Department					or entity to which it is addressed and may contain information that is privileged						
1305 Corporate Center Drive					nfidential. If	the reader	of this	message	e is not the intended recipient, or		
Eagan, Minnesota 55121				the employee or agent responsible for delivering the message of the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this							
TOLL FREE				communication in error, please notify us immediately using 1-800-363-2446 to call us or fax us the information you received in error. You may also call us							
Fax: 877.480.8130				collect using the above telephone number. Please destroy or return the original							

message to us at the above address via the U.S. Postal Office.