COPAY WAIVER
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber 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's Diagnosis - ICD code plus description**:**

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

For ALL Requests:

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Please list all reasons for selecting the requested **medication, dosing schedule, and quantity** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): _____
3. 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.)

_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____

For Aspirin Therapy:

5. For use in pregnancy: Is the patient at high risk of preeclampsia and using the requested agent after 12 weeks of gestation? ☐ 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
8. Is the requested agent being used for the primary prevention of cardiovascular disease (CVD)? ☐ Yes ☐ No
9. Does the patient have a 10% or greater 10-year CVD risk? ☐ Yes ☐ No
10. Is the requested agent being used for the primary prevention of colorectal cancer (CRC)? ☐ Yes ☐ No

For Folic Acid Therapy:

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

For Iron Supplement Therapy:

12. Is the patient at increased risk of iron deficiency anemia? ☐ Yes ☐ No
    If yes, please explain: _____

Please continue on page 2.

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

For Bowel Prep Therapy:

13. Will the requested agent be used for the preparation of colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy? ..... ☐ Yes ☐ No

For Statin Therapy:

14. Is the requested agent for use in the primary prevention of cardiovascular disease (CVD)? ..... ☐ Yes ☐ No
15. Does the patient have any of the following CVD risk factors? **(Check all that apply)**
    - ☐ Dyslipidemia
    - ☐ Diabetes
    - ☐ Hypertension
    - ☐ Smoking
16. 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? ..... ☐ 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: 877.480.8130

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