

ALISKIREN-CONTAINING AGENTS (AMTURNIDE, TEKAMLO, TEKTRUNA) PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

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

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit <https://www.bcbstx.com/provider/medicaid/pharmacy/star-kids-prior-auth>

PATIENT AND INSURANCE INFORMATION			Today's Date:	
Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	
Patient Address:		City, State, Zip:		Patient Telephone:
BCBSTX 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:
1. Is the patient currently treated with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested medication started? _____	
2. Does the patient have a diagnosis of hypertension in the last 365 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Does the patient have a diagnosis of pregnancy in the last 310 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Does the patient have a diagnosis of renal artery stenosis in the last 365 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Does the patient have a diagnosis of diabetes mellitus in the last 730 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Does the patient have history of a cyclosporine or itraconazole agent in the past 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Please list the medications the patient has previously tried and failed for treatment of this diagnosis (Please specify if brand name, generic, extended-release products, or over-the-counter products):	
_____	Date: _____
_____	Date: _____
_____	Date: _____
8. Please list all reasons for selecting the requested medication over alternatives (e.g., contraindications, allergies or history of adverse drug reactions). _____	
9. Please list all other medications the patient is currently taking for treatment of this diagnosis. _____	

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility Authorization does not guarantee payment.

Please fax or mail this form to:
 Prime Therapeutics LLC, Clinical Review Department
 2900 Ames Crossing Road
 Eagan, Minnesota 55121

TOLL FREE
Fax: 877.243.6930 Phone: 855.457.1200

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