ANTI-COVID19
QUANTITY LIMIT 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 preauthorization 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/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:

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Is the patient using the requested agent for a COVID-19 reinfection? ☐ Yes ☐ No
3. Is the requested agent being used to extend treatment beyond the maximum FDA Emergency Use Authorization (EUA) treatment regimen for the requested indication? ☐ Yes ☐ No
4. Is the requested agent being used in combination with another agent in this program (Molnupiravir, Paxlovid) for the requested indication? ☐ Yes ☐ No
5. Does the requested quantity (dose) exceed the maximum FDA EUA dosing for the requested indication? ☐ Yes ☐ No
6. 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: _____ _____ Date: _____

   _____ Date: _____ _____ Date: _____

   _____ Date: _____ _____ Date: _____
7. Please list all reasons for selecting the requested **medication, strength, dosing schedule, and quantity** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions, lower dose tried.) _____

   _____
8. Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. _____

   _____

Please continue to page 2.

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

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: 800.285.9426

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 notify the sender immediately by telephone at 866.202.3474 and return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.