DISPENSING LIMIT OVERRIDE

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/yyyy):
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:

For All Requests:

1. Is the patient currently treated with the requested dose of the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested dose started? _____
   For topical agents, is the request for treatment of an area of the skin not previously treated? ☐ Yes ☐ No
2. Please list all reasons for selecting the requested **medication, quantity and dosing schedule** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried). _____
3. 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 or generic products.)
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
4. Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. **(Please include strength and quantity per month)**
   _____ Quantity: _____ _____ Quantity:_____
   _____ Quantity: _____ _____ Quantity:_____

For Gralise:

5. Does the patient require an increased quantity to accommodate a titration schedule? ☐ Yes ☐ No
   If yes, will the dosage be titrated up over 15 days? ☐ Yes ☐ No

For Insomnia Oral Agents:

6. Is the patient currently taking an Insomnia oral agent? ☐ Yes ☐ No
   If yes, is the intent to switch therapy to the requested medication? ☐ Yes ☐ No

For Low Molecular Weight Heparins (LMWH) and Arixtra:

7. Does the patient require extended treatment for primary or secondary prophylaxis of thromboembolism during pregnancy and/or puerperium? ☐ Yes ☐ No
   If no, does the patient require extended prophylaxis and/or treatment of symptomatic VTE (DVT and/or PE)? ☐ Yes ☐ No
   If yes to the above, does patient have cancer? ☐ Yes ☐ No

Please continue on page 2

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

For Ophthalmic Prostaglandins:

8. Is the patient or care provider not able to properly instill eye drops without excess wastage?..... ☐ Yes ☐ No

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