



MEDICARE PART D PRESCRIPTION DRUG AUTHORIZATION REQUEST FORM

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

- STANDARD REQUEST
 EXPEDITED REQUEST

GENERAL INFORMATION Request Type (please check one)

Prior Authorization
 Step Therapy Exception
 Request Non-formulary Drug
 Request for Tiering Exception
 Request for Quantity Limit Exception
 Appeal

Patient Name			Date of Birth (mm/dd/yyyy)									
Patient's Home Address			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>									
City	State	Zip	Contract Number (Include Prefix)									
Patient Phone Number			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>									

PHYSICIAN INFORMATION

Physician Name			Practice Type: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist		
Practice Address			Physician UPIN		
City	State	Zip	Provider Number		
Office Phone		Office Fax			

PHYSICIAN INFORMATION

Drug Requested:	Dose Requested:	
Reason for Use:		
ICD-9 Related to Use:	Duration of Disease:	
List other medication this patient has tried with this condition:		
Drug: _____	Regimen: _____	Dates of Therapy: _____ to _____
Drug: _____	Regimen: _____	Dates of Therapy: _____ to _____
Drug: _____	Regimen: _____	Dates of Therapy: _____ to _____
Does this patient have any co-morbid conditions that will affect therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, please list: _____		
I certify this information is correct. I understand that intentional misrepresentation of information herein may constitute fraud and be subject to legal action.		
Recertification is required annually. _____		Date _____

BlueRx (PDP) is a Medicare Approved Part D Sponsor plan offered by Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association. Prime Therapeutics, an independent company, manages pharmacy benefits for BlueRx (PDP) members on behalf of Blue Cross and Blue Shield of Alabama.

SUBMISSION INSTRUCTIONS:

FAX

You may fax the signed and completed form to Clinical Review Dept. at: **1-800-693-6703**

MAIL

You may mail the signed and completed form to:
Prime Therapeutics LLC
Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121