Print Reset

Prescription Drug Prior Authorization Form

Fax this form to 1-866-804-8818 A fax cover sheet is not required.

Prime Therapeutics Management, LLC partners with CoverMyMeds on behalf of Unified Labor Rx to allow for the submission of electronic PA requests. **For faster coverage determinations, go to www.CoverMyMeds.com.**

Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). Information contained in this form is Protected Health Information under HIPAA.

Date of Request: _____ ☐ **Non-Urgent** ☐ **Exigent Circumstances**

MEMBER INFORMATION

Member's Last Name: _____

Member's First Name: _____

Member's ID: _____ Date of Birth: _____ Member's Phone: _____

Member's Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Height: _____ ☐ in. ☐ cm Weight: _____ ☐ lbs. ☐ kg

Allergies: _____

If you are not the member or prescriber, please submit a PHI Disclosure Authorization form with this request, located at https://unifiedlaborrx.primetherapeutics.com.

PRESCRIBER INFORMATION

Prescriber's Last Name: _____

Prescriber's First Name: _____

Specialty: _____ Email: _____

Prescriber's NPI: _____ DEA #: _____

Prescriber's Phone: _____ Prescriber's Fax: _____

Prescriber's Street Address: _____

City: _____ State: _____ Zip: _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Number of Refills: _____ Day Supply: _____

☐ New Therapy ☐ Renewal If renewal, date therapy initiated: _____

Member's Full Name: _____

If renewal, duration of therapy (specific dates): _____ to _____

DISPENSING INFORMATION

How did the member receive the medication?

☐ Paid Under Insurance

Prior Authorization # (if known): _____

Insurance Name: _____

☐ Other (explain): _____

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other: _____

Administration Location:

☐ Member's Home ☐ Long-Term Care ☐ Physician's Office

☐ Home Care Agency ☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care

☐ Other (explain): _____

DIAGNOSIS AND MEDICAL INFORMATION

1. Has the member tried any other medications for this condition?

   ☐ Yes ☐ No

   a. If **Yes**, what was the medication therapy (specify drug name and dosage)?

   b. What was the duration of therapy? Specify dates: _____ to _____

   c. What was the response, reason for failure, or allergy?

2. What are the member's diagnoses and ICD-10 codes?

   Diagnoses: _____

   ICD-10 codes: _____

Member's Full Name: _____

3. **What additional clinical information do you have that is relevant to this request for a prior authorization?** Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if the member has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: _____ **Date:** _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Mail requests to:

Prime Therapeutics Management, LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 1-844-654-2111

Fax this form to 866-804-8818