



COX 2 INHIBITOR
PRIOR AUTHORIZATION REQUEST
PHYSICIAN FAX FORM

Only the prescriber may complete this form

The following documentation is REQUIRED for prior authorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Kansas Web site at www.bcbsks.com Today's Date:

PATIENT INFORMATION

Form with fields for Patient Name (First), Last, M, DOB (mm/dd/yyyy), Patient Address, City, State, Zip, and Patient Telephone.

INSURANCE INFORMATION

Form with fields for BCBS ID Number and Group Number.

PHYSICIAN/CLINIC INFORMATION

Form with fields for Prescriber Name, Physician NPI#, Specialty, Contact Name, Clinic Name, Clinic Address, City, State, Zip, Phone #, and Secure Fax #.

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Form with multiple sections for Patient's Diagnosis, Medication Requested, Dosing Schedule, and numbered questions regarding diagnosis, previous treatments, and current medications.

Please fax or mail this form to:

Prime Therapeutics LLC
Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 Phone: 866.469.5660

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.

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Prime Therapeutics LLC is an independent limited liability company providing pharmacy benefit management services.