



BIOLOGIC IMMUNOMODULATORS PRIOR AUTHORIZATION 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.

PATIENT INFORMATION

Today's Date: _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

INSURANCE INFORMATION

BCBS ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician 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

Please note: Humira is preferred and must be tried and failed prior to approval of another biologic agent unless inappropriate for patient's diagnosis.

Patient's Diagnosis - ICD-9 code plus description: _____

Medication Requested: _____ Strength: _____

Dosing Schedule: _____ Quantity per Month: _____

- Is the patient currently treated with the requested medication? Yes No
If yes, when was treatment with the requested medication started? _____
- For renewal of Amevive, has there been a minimum of 12 weeks since the end of the previous course of Amevive? Yes No
- Please list all other medications the patient is **currently taking for treatment of this diagnosis**. _____
- Please list the medications the patient has **previously tried and failed for treatment of this diagnosis**:
 _____ Date: _____ Date: _____
 _____ Date: _____ Date: _____
 _____ Date: _____ Date: _____
- Please list all reasons for selecting the requested **medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____
- If the patient has been previously treated with another biologic (Actemra, Amevive, Cimzia, Enbrel, Humira, Kineret, Orencia, Remicade, Rituxan, Simponi, Stelara) will this drug be discontinued prior to the start of the requested medication? Yes No

This optional prescription order form can be used for Triessent Specialty Pharmacy (888-216-6710)

MEDICATION	STRENGTH	QUANTITY	DIRECTIONS FOR USE	REFILLS

Ancillary supplies as needed per injection (i.e. needles, syringes, alcohol wipes)

Does the patient require training? Yes No

Prescriber Signature (required): _____ Date: _____

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

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