

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/yy):
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

Patient's Diagnosis - ICD-9 code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
1. Is the patient currently treated with the requested medication?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested medication started? _____	
2. Has the patient completed the appropriate FDA approved genetic test (if applicable) and results indicate therapy with the requested medication is appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate genetic test: _____	
3. Please list all reasons for selecting the requested medication, dosing schedule and quantity over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried.) _____ _____ _____	
4. Please list all other medications the patient is currently taking for treatment of this diagnosis. _____ _____ _____	
5. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. _____ _____ _____	

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

MEDICATION	STRENGTH	QUANTITY	DIRECTIONS FOR USE	REFILLS

Prescriber Signature (required): _____ **Date:** _____

Please fax or mail this form to:
 Prime Therapeutics LLC
 1305 Corporate Center Drive
 Eagan, Minnesota 55121
TOLL FREE
Fax: 877.480.8130 Phone: 866.469.5660

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