FORMULARY EXCEPTION
PHYSICIAN FAX FORM

ONLY the prescriber may complete this form.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Florida web site at *http://www.bcbsfl.com.*

Today's Date: ______________________

PATIENT INFORMATION

Patient Name (First):	Last:	MI:	DOB (mm/dd/yyyy):

INSURANCE INFORMATION

BCBS ID Number:	Group Number:

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:

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

1. Is the patient currently treated with the requested medication? .... ☐ Yes ☐ No

   If yes, when was treatment with the requested medication started? ______________________

2. Please list all reasons for selecting the requested **medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) ______________________

3. Please list all medications the patient has **previously tried and failed for treatment of this diagnosis.** (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) ______________________

4. Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. ______________________

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130

Phone: 888.271.3183

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