

**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 Florida Blue web site at <http://www.floridablue.com>

Today's Date: _____

PATIENT INFORMATION

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

INSURANCE INFORMATION

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: _____
<p>1. Is the patient currently treated with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, when was treatment with the requested medication started? _____</p> <p>2. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____</p> <p>_____</p> <p>_____</p> <p>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.) _____</p> <p>_____</p> <p>_____</p> <p>4. Please list any other medications the patient will use in combination with the requested medication for treatment of this diagnosis. _____</p> <p>_____</p>	

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: 888.271.3183

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