

**QUANTITY LIMIT  
PHYSICIAN FAX FORM**



**BlueCross BlueShield  
of Florida**

An Independent Licensee of the  
Blue Cross and Blue Shield Association

**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:	M:	DOB (mm/dd/yy):	Patient Telephone Number:
-----------------------	-------	----	-----------------	---------------------------

**INSURANCE INFORMATION**

Insurance 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 - ICD-9 code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<p>1. Please list all reasons for selecting the requested <b>medication, strength, dosing schedule and quantity</b> over alternatives: (e.g. contraindications to other medications; lower dose has been tried.) _____</p> <p>_____</p>	
<p>2. Please list all medications the patient has <b>previously tried and failed</b> for treatment of this diagnosis. (Please specify if the patient has tried brand-name products or generic products.) _____</p> <p>_____</p>	
<p>3. Please list any other medications the patient will use in <b>combination</b> with the requested medication for treatment of this diagnosis. _____</p> <p>_____</p>	
<p>4. Is the prescribed dose higher than the maximum dose recommended in FDA-approved labeling (i.e., the package insert)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature.)</p>	
<p><b>If the requested medication is a triptan (such as Imitrex):</b></p> <p>5. Has the patient been evaluated for chronic daily headache caused by medication overuse?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p><b>If the requested medication is a low molecular weight heparin (such as Lovenox):</b></p> <p>6. Has the patient tried and failed Coumadin (warfarin)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain the reason _____</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:** 800.693.6703      **Phone:** 800.693.6651

**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. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 800.858.0723, and return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.