

**QUANTITY LIMIT
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:	M:	DOB (mm/dd/yy):	Patient Telephone Number:
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INSURANCE INFORMATION

Insurance ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician UPIN#:	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:
<p>1. Please list all reasons for selecting the requested medication, strength, dosing schedule and quantity 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 previously tried and failed 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 combination 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>If the requested medication is a triptan (such as Imitrex):</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>	

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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