MEDICARE PART D
TIER EXCEPTION
PHYSICIAN FAX FORM

Blue Cross MedicareRx (PDP)℠

ONLY the prescriber may complete this form. This form is for Medicare Part D prospective, concurrent, and retrospective reviews.

Please fax or mail this form to: **TOLL FREE** **Fax: 800-693-6703 Phone: 800-693-6651**	**Prime Therapeutics LLC** **Attn: Medicare Appeals Department** **1305 Corporate Center Dr, Bldg N10** **Eagan, MN 55121**

The following documentation is REQUIRED. For formulary information, please visit www.myprime.com and search for the appropriate health plan formulary.

☐ Standard review (initial coverage determination decision completed within 72 hours)
☐ Expedited review (initial coverage determination decision completed with 24 hours in instances where standard decision time could be seriously harmful to your life, health, or ability to regain maximum function)

PATIENT, INSURANCE and PHYSICIAN/CLINIC INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Insurance ID Number:		Patient Telephone Number:	
Prescribing Physician's Name:	Physician NPI#:	Specialty:	Clinic Contact Person's Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Clinic Phone #:	Clinic Secure Fax #:
Is the patient a long term care facility resident? ☐ Yes ☐ No If yes, please provide the LTC facility contact's name, telephone and fax numbers			
LTC Contact Name:		LTC Phone #:	LTC Secure Fax #:

Diagnosis- ICD code plus description:	Patient's Weight (kg)
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? _____
   -Is the patient currently taking a lower dose of the requested medication? (this request is for a higher dose) ☐ Yes ☐ No
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.)
   _____ Date: _____ Reason for failure: _____
   _____ Date: _____ Reason for failure: _____
   _____ Date: _____ Reason for failure: _____
4. Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. _____

MyPrime is a pharmacy benefit website owned and operated by Prime Therapeutics LLC, an independent company providing pharmacy benefit management services. Blue Cross MedicareRx is a prescription drug plan provided by HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC's plan depends on contract renewal.