



**Prior Authorization/Step Therapy  
GatorCare Prescriber Fax Form  
Fax this form to 888-272-1349**

Prime Therapeutics Management LLC partners with CoverMyMeds to allow for the submission of electronic PA requests. **For faster coverage determinations, go to [www.CoverMyMeds.com](http://www.CoverMyMeds.com).**

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews. Incomplete forms will be returned for additional information.** The following documentation is required for preauthorization consideration. For formulary information visit [primetherapeutics.com/commercial-formularies](http://primetherapeutics.com/commercial-formularies).

What is the priority level of this request?

- Standard
- Date of service (if applicable): \_\_\_\_\_
- Urgent (**Note:** Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

Today's Date: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Last Name: \_\_\_\_\_

Patient First Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  Male  Female Height: \_\_\_\_\_  in.  cm Weight: \_\_\_\_\_  lbs.  kg

Allergies: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Last Name: \_\_\_\_\_

Prescriber First Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ Email: \_\_\_\_\_

Prescriber NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_ Prescriber Fax: \_\_\_\_\_

Prescriber Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's Name (Last, First): \_\_\_\_\_

## DRUG INFORMATION

---

Drug Name: \_\_\_\_\_ Drug Form: \_\_\_\_\_

Drug Strength: \_\_\_\_\_ Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_ Quantity: \_\_\_\_\_

Number of Refills: \_\_\_\_\_ Day Supply: \_\_\_\_\_

New Therapy  Renewal If renewal, date therapy initiated: \_\_\_\_\_

If renewal, duration of therapy (specific dates): \_\_\_\_\_ to \_\_\_\_\_

## CRITERIA FOR ALL REQUESTS

---

**Note:** Please attach any additional information that should be considered with this request.

### Patient's Diagnosis:

ICD (Code): \_\_\_\_\_

ICD Description: \_\_\_\_\_

1. Is the patient currently treated with the requested medication?

Yes  No

**If Yes,** how did the patient receive the medication?

Insurance (list name): \_\_\_\_\_

Samples

Other (please explain): \_\_\_\_\_

2. Has the patient been treated with the requested agent within the past 90 days?

Yes  No

**If Yes,** is the patient at risk if therapy is changed?

Yes  No

**If Yes,** explain:

\_\_\_\_\_

3. Please list all other medications the patient will use in combination with the requested medication for the treatment of this diagnosis.

\_\_\_\_\_

4. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA maximum).

\_\_\_\_\_

Patient's Name (Last, First): \_\_\_\_\_

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

Medication: \_\_\_\_\_ Type: \_\_\_\_\_

Date (from): \_\_\_\_\_ Date (to): \_\_\_\_\_

Medication: \_\_\_\_\_ Type: \_\_\_\_\_

Date (from): \_\_\_\_\_ Date (to): \_\_\_\_\_

Medication: \_\_\_\_\_ Type: \_\_\_\_\_

Date (from): \_\_\_\_\_ Date (to): \_\_\_\_\_

### **CRITERIA FOR BEHAVIORAL HEALTH DIAGNOSES**

---

6. Please list all reasons for selecting the requested medication over alternatives (e.g., contraindications, risk with change, started on while in hospital, allergies or history of adverse drug reactions, lower dose).

Attachments

### **ATTESTATION**

---

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(By signature, the physician confirms the above information is accurate and verifiable by patient records.)*

**Please fax or mail this form to:**

Prime Therapeutics Management LLC

Attn: CP – 4201

P.O. Box 64811

St. Paul, MN 55164-0811

Phone: 1-800-651-8921

**Fax this form to 888-272-1349**

**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 return the original message to Prime Therapeutics Management LLC via U.S. Mail. Thank you for your cooperation.