DISPENSE AS WRITTEN (DAW) / MEMBER-PAY-THE-DIFFERENCE
PENALTY WAIVER
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.
By submitting this form, you attest that all information provided is true and accurate.

PLEASE NOTE: Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit www.myprime.com

PATIENT AND INSURANCE INFORMATION **Today's date: _____**

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):
Patient Street Address:	City, State:	ZIP:	Patient Phone:
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

MEDICAL INFORMATION. PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED.

Patient Diagnosis with ICD-9 Code:	ICD-10 Code:
Medication and Strength Requested:	
Dosing Schedule:	Quantity per Month:

ALL REQUESTS

Is the patient currently being treated with the requested agent? ..... ☐ Yes ☐ No

Is the generic drug subject to an on-going shortage confirmed by the American Society of Health-System Pharmacists (ASHP) for the Food and Drug Administration (FDA)? ..... ☐ Yes ☐ No

INITIAL REQUESTS

Has the prescriber indicated on the prescription "Dispense As Written (DAW)"? ..... ☐ Yes ☐ No

Has the patient tried an AB-rated generic equivalent to the brand agent? ..... ☐ Yes ☐ No

Does the patient have a documented allergic reaction to an inactive ingredient that is present in the generic formulation but absent in the brand name equivalent? ..... ☐ Yes ☐ No

If no, has the patient had a documented side effect or adverse event to a generic medication that did not occur with the brand name equivalent? ..... ☐ Yes ☐ No

Please continue to the next page.

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):

Has the prescriber documented that the patient experienced an adverse event to the generic formulation on an FDA MedWatch Adverse Event Reporting Form and submitted that form to the FDA on behalf of this patient? ..... ☐ Yes ☐ No

If yes: Documentation including a copy of the MedWatch Adverse Event Reporting form is required.

RENEWAL REQUESTS

Was the patient previously approved for the requested agent through the FL Blue member-pay-the-difference (MPTD) penalty waiver review process? ..... ☐ Yes ☐ No

If no, please complete the Initial Requests section.

Is the patient compliant with the requested agent in the past 120 days? ..... ☐ Yes ☐ No

If yes: Please explain: _____

_____

Please indicate:

☐ Date of service (if applicable): (mm/dd/yyyy): _____

☐ Start of treatment: Start date (mm/dd/yyyy): _____

☐ Continuation of therapy: Date of last treatment (mm/dd/yyyy): _____

What is the priority level of this request?

☐ Standard

☐ 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.)

If yes: Please specify:_____

_____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183