HIV PREP
TIER EXCEPTION REQUEST
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:

Please list the medications the patient has previously tried and failed for the treatment of this diagnosis:

_____ Date range: _____ _____ Date range:

_____ Date range: _____ _____ Date range:

_____ Date range: _____ _____ Date range:

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

Is the requested agent being used for PrEP?. ..... ☐ Yes ☐ No

Is the requested agent medically necessary compared to other available PrEP agents? ..... ☐ Yes ☐ No

Is the requested agent one of the following: 1) a tenofovir disoproxil fumarate and emtricitabine combination ingredient agent, 2) a tenofovir disoproxil fumarate single ingredient agent, or 3) a tenofovir alafenamide and emtricitabine combination ingredient agent?..... ☐ Yes ☐ No

If no, are tenofovir disoproxil fumarate and emtricitabine combination ingredient agent, a tenofovir disoproxil fumarate single ingredient agent, or a tenofovir alafenamide and emtricitabine combination ingredient agent contraindicated, likely to be less effective, or will cause an adverse reaction or other harm for the patient?..... ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

Please continue to the next page.

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

Is the patient at high risk of HIV infection?..... ☐ Yes ☐ No

Has the patient recently tested negative for HIV?..... ☐ Yes ☐ No

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 max).

_____

_____

_____

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