MEDICARE PART D
OPIOIDS ER
PRESCRIBER FAX FORM

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: 855-212-8110 Phone: 800-693-6651**	**Prime Therapeutics LLC** **Attn: Medicare Appeals Department** **2900 Ames Crossing Road Suite 200** **Eagan, MN 55121**

The following documentation is REQUIRED. For formulary information, please visit www.myprime.com and search for the appropriate health plan formulary. To submit this form electronically, please click here or go to covermymeds.com.

Per CMS requirements – all standard requests are completed within 72 hours (including weekends)
If you request an expedited review, you certify that applying the 72-hour standard review time frame could seriously harm the patient's life, health or ability to regain maximum function. Please check the box to request an expedited review: ☐

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

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Insurance ID Number:		Patient Telephone Number:	
Prescriber Name:	Prescriber 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 #:	
Patient's Diagnosis (ICD code, plus description):			
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? _____
2. Is the medication being prescribed as an as-needed analgesic? ☐ Yes ☐ No
3. Does the prescriber have a patient-specific pain management plan on file for the patient (please attach the patient's medical history including pharmacological and non-pharmacological therapies)? ☐ Yes ☐ No
4. Does the patient have any FDA-labeled contraindications to the requested agent? ☐ Yes ☐ No
5. Has the prescriber reviewed the patient's records in the state's prescription drug monitoring program (PDMP) AND determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose? ☐ Yes ☐ No
6. Does the patient's medication history include use of an immediate-acting opioid? ☐ Yes ☐ No
   If no, does the patient have an intolerance or hypersensitivity to an immediate-acting opioid? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
   If no, does the patient have an FDA labeled contraindication to an immediate-acting opioid? ☐ Yes ☐ No
   If yes, please specify: _____
   _____
7. Please list all reasons for selecting the **requested medication, dosing schedule, and quantity** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried). _____
   _____
8. Please list all the medications the patient has **tried and failed** for treatment of this diagnosis:
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
9. Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. _____
   _____