HP ACTHAR

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax 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 prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/star_kids_prior_auth.html

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

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis-ICD code plus description:

Medication Requested: Strength:

***Your request will be reviewed for the generic equivalent unless you specify brand is required.**

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. Does the patient have a diagnosis of infantile spasms in the last 730 days? ☐ Yes ☐ No
3. Does the patient have a diagnosis of multiple sclerosis in the last 730 days? ☐ Yes ☐ No
4. Does the patient have a documented contraindication or intolerance to corticosteroid therapy? ☐ Yes ☐ No
   If yes, please explain: _____
5. Does the patient have a diagnosis of scleroderma, osteoporosis, systemic fungal infection, ocular herpes simplex, peptic ulcer and/or heart failure in the last 365 days? ☐ Yes ☐ No
6. Please list the medications the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if brand name, generic, extended-release products, or over-the-counter products)**:**
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
7. Please list all reasons for selecting the **requested medication** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions). _____
   _____
8. Please list all other medications the patient is **currently taking** for treatment of this diagnosis. _____
   _____
   _____

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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

TOLL FREE

Fax: 877.243.6930 **Phone: 855.457.1200**

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 notify the sender immediately by telephone at 866.202.3474 and return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.