MORPHINE EQUIVALENT DOSE OVERRIDE
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/rx_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:

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 cancer, palliative care or hospice care in the last 365 days? ☐ Yes ☐ No
3. Does the patient have a history of an antineoplastic agent in the last 90 days? ☐ Yes ☐ No
4. What is the patient's total opiate intake per day? ______________________ Morphine equivalent doses (MEDs)
5. 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): ________
6. Please list all reasons for selecting the **requested medication and dose** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions).____
   ____
   ____
7. 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: 855.457.0407**

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