

# STEP THERAPY AUTHORIZATION PHYSICIAN FAX FORM



**ONLY the prescriber may complete this form.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information.

Today's Date: \_\_\_\_\_

### PATIENT INFORMATION

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Patient Telephone Number:
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### HEALTH PLAN INFORMATION

BlueLink TPA ID Number:	Group Number:
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### PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician 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:
Medication Requested:
<p>1. Is the patient currently treated with the requested medication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested medication started? _____</p> <p>2. Please list all reasons for selecting the requested <b>medication</b> over alternatives (e.g. contraindications, allergies or history of adverse drug reactions.) _____ _____</p> <p>3. Please list all other medications the patient is <b>currently taking for treatment of this diagnosis.</b> _____ _____</p> <p>4. Please list any other medications the patient has <b>previously tried and failed for treatment of this diagnosis.</b> (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) _____ _____</p>
<p><b>If the requested medication is a Cox-2 inhibitor (such as Celebrex)</b> Is the patient currently taking:</p> <p>1. Systemic corticosteroids on a regular basis (e.g. long-term daily or pulse therapy)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. An anticoagulant (e.g. warfarin?) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>If the requested medication is statin (such as Lipitor) please provide:</b></p> <p>1. Patient's baseline (pretreatment) fasting lipid panel: Total Cholesterol _____ TRI _____ HDL _____ LDL _____</p> <p>2. Patient's goal LDL _____ OR goal % LDL reduction _____</p>

**Please fax or mail this form to:**  
Prime Therapeutics LLC  
Clinical Review Department  
1305 Corporate Center Drive  
Eagan, Minnesota 55121

**TOLL FREE**

**Fax:** 877.480.8130      **Phone:** 866.202.3474

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