

**QUANTITY LIMIT  
PHYSICIAN FAX FORM FOR MEDICAID 2011**



**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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**INSURANCE INFORMATION**

Member 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 #:

Patient's Diagnosis - ICD-9 code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<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 reasons for selecting the requested <b>strength, dosing schedule and quantity</b> over alternatives (e.g. lower dose has been tried.) _____ _____</p> <p>4. Please list all medications the patient has <b>previously tried and failed</b> for treatment of this diagnosis. (Please specify if the patient has tried brand-name products or generic products.) _____ _____</p> <p>5. Please list any other medications the patient will use in <b>combination</b> with the requested medication for treatment of this diagnosis. _____ _____</p>	
<p><b>If the requested medication is a triptan (such as Imitrex):</b></p> <p>6. Has the patient been evaluated for chronic daily headache caused by medication overuse? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

<p><b>Please fax or mail this form to:</b> Prime Therapeutics LLC Clinical Review Department 1305 Corporate Center Drive Eagan, Minnesota 55121</p> <p><b>TOLL FREE</b></p> <p><b>Fax: 877.480.8130      Phone: 866.202.3474</b></p>	<p><b>CONFIDENTIALITY NOTICE:</b> 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 800.858.0723, and return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p>
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