COVERAGE EXCEPTION
PHYSICIAN FAX FORM

Florida Blue
In the pursuit of health®

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information, please visit the Florida Blue web site at http://www.floridablue.com

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	

INSURANCE INFORMATION

ID Number:	Group Number:

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 – 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. Please list all reasons for selecting the requested **medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____
   _____
   _____
3. Please list all medications the patient has **previously tried and failed for treatment of this diagnosis.** (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.)

   _____ Date: _____ _____ Date: _____
   _____ Date: _____ _____ Date: _____
   _____ Date: _____ _____ Date: _____
4. Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. _____
   _____

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: 888.271.3183**

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