DEPARTMENT OF HUMAN SERVICES

Prime THERAPEUTICS™

Minnesota Health Care Programs
Prescription Drug Prior Authorization Form

Fax this form to 866-390-2778. **A fax cover sheet is not required.**

This form is for requesting prior authorization for outpatient drugs dispensed at a pharmacy. If you would like to request prior authorization for a drug administered at a clinic or other outpatient setting, please use the medical authorization request (DHS-4695) (PDF). The Minnesota Department of Human Services contracts with the MHCP Prescription Drug PA Review Agent, Prime Therapeutics State Government Solutions LLC, to provide drug prior authorization services. Direct all inquiries regarding PAs – including questions on criteria and status of PA – to the Prime Therapeutics Pharmacy Minnesota Health Care Programs Pharmacy Call Center at 844-575-7887. Access criteria information and forms through the MHCP Pharmacy website at https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/types/#47.

Obtain authorization by calling the Prime Therapeutics Pharmacy Minnesota Health Care Programs Pharmacy Call Center with the following information or by faxing the completed form.

Date of Request: ______________________________

REQUESTER INFORMATION

Requester Last Name: ______________________________

Requester First Name: ______________________________

Requester Phone: ______________________ Requester Affiliation: ☐ Pharmacy ☐ Prescriber

Prescriber Name: ______________________ Prescriber NPI: ______________________

Prescriber Phone: ______________________ Prescriber Fax: ______________________

☐ Renewal of Expired Authorization PA# of Expired Authorization: ______________________

☐ Copay-Only Authorization Amount Paid by Primary Insurance: ______________________

☐ Patient Between Prepaid Health Plans

☐ Other (specify): ______________________________

MEMBER INFORMATION

Member Last Name: ______________________________

Member First Name: ______________________________

Member ID: ______________ Date of Birth: ______________ Member Phone: ______________

Sex: ☐ Male ☐ Female Allergies: ______________________________

Height: ______________________ Weight: ______________________(kg)

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Member's Full Name: ______________________________

DRUG INFORMATION

Drug Name: ______________________ Drug Form: ______________

Drug Strength: ______________________ Dosing Frequency: ______________

Authorization Start Date: ______________ Length of Therapy: ______________

Quantity: ______________________ Number of Refills: ______________

Days' Supply: ______________________

If renewal, duration of therapy (specific dates): ______________ to ______________

DISPENSING INFORMATION

Route of Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other: ______________

DIAGNOSIS AND MEDICAL INFORMATION

1. Is the member being treated for a chronic condition?

   ☐ Yes ☐ No

2. Is this condition expected to require continuous treatment with the requested drug for more than 1 year?

   ☐ Yes ☐ No

3. Has the member tried any other medications for this condition?

   ☐ Yes ☐ No

   a. If **YES**, what was the medication therapy (specify drug name and dosage)?

      ____

   b. What was the duration of therapy? Specify dates: ______________ to ______________

   c. What was the response, reason for failure, or allergy?

      ____

4. What are the member's relevant diagnoses and ICD-10 codes?

   Diagnoses: ______________________________

   ICD-10 codes: ______________________________

Member's Full Name: ______________________________

5. **What additional clinical information do you have that is relevant to this request for a prior authorization?** Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if the member has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Pharmacists may dispense up to a 72-hour supply of the prescribed medication. A 72-hour supply may be approved at point of sale when a level of service of 3 is entered on the claim. However, additional supplies will not be authorized if PA criteria are not met.

Mail requests to:

Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 844-575-7887

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