

**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: \_\_\_\_\_

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. 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?

\_\_\_\_\_

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

Diagnoses: \_\_\_\_\_

ICD-10 codes: \_\_\_\_\_

Member's Full Name: \_\_\_\_\_

3. **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

**Fax this form to 866-390-2778**