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DEPARTMENT OF HUMAN SERVICES

Prime THERAPEUTICS

Minnesota Health Care Programs
Indian Health Services

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 faxing the completed form to Prime Therapeutics Pharmacy Minnesota Health Care Programs Pharmacy Call Center.

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: _____

Indian Health Services (IHS) Pharmacy Name: _____

IHS Pharmacy NPI: _____

☐ 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: _____

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.

Member's Full Name: _____

☐ 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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