COVERAGE EXCEPTION
PHYSICIAN FAX FORM

Florida Blue
In the pursuit of health®

This form applies to members that have plans for individuals under 65 or small group and individuals under 65 from the Health Marketplace.

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.
By submitting this form, you attest that all information provided is true and accurate.

PLEASE NOTE: Incomplete forms will be returned for additional information. To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit the Florida Blue website at http://www.floridablue.com

What is the priority level of this request?

☐ Standard
☐ Date of service (if applicable): _____
☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

PATIENT INFORMATION **Today's date: _____**

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):
Patient Street Address:	City, State	ZIP	Patient Phone:

INSURANCE INFORMATION

Member ID Number:	Group Number:

PRESCRIBER/CLINIC INFORMATION

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		Zip:

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		Zip:

MEDICAL INFORMATION. PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED.

Patient Diagnosis with ICD-9 Code:	ICD-10 Code:
Medication and Strength Requested:	
Dosing Schedule:	Quantity per Month:

Please list the medications the patient has **previously tried and failed for the treatment of this diagnosis:**

_____ Date: _____ _____ Date: _____
_____ Date: _____ _____ Date: _____
_____ Date: _____ _____ Date: _____

Is the patient currently treated with the requested medication? ..... ☐ Yes ☐ No
If yes: When was treatment with the requested medication started? _____

Please list all reasons for selecting the requested **medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____
_____

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: 855.212.8110 **Phone: 888.271.3183**