

**REVATIO AUTHORIZATION  
PHYSICIAN FAX FORM**



**ONLY the prescriber may complete this form.**

FirstPlan of Minnesota - Providing comprehensive coverage in your community since 1944.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information, please visit the FirstPlan web site at [www.firstplan.org](http://www.firstplan.org).

**Today's Date:** \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Patient Telephone Number:
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**HEALTH PLAN INFORMATION**

Blue Cross ID Number:	Group Number:
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**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:	
Medication Requested:	Strength:
<p>1. Is the patient currently treated with the requested medication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, when was treatment with the requested medication started? _____</p> <p>2. Please list all reasons for selecting the requested <b>medication</b> over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____</p> <p>_____</p> <p>_____</p> <p>3. Please list all other medications the patient is <b>currently taking for treatment of this diagnosis.</b> _____</p> <p>_____</p> <p>_____</p> <p>4. Please list all medications the patient has <b>previously tried and failed for treatment of this diagnosis.</b> (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) _____</p> <p>_____</p> <p>_____</p>	

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 1020 Discovery Road, No. 100  
 Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.480.8130      Phone: 866.202.3474**

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