

## **Important Information about Prescription Drug Coverage**

---

To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Request for Step Therapy Exception: Please Respond.

- Please complete the attached Request for Step Therapy Exception Form.
- To prevent delays in the review process please complete all requested fields.
- Completed forms should be faxed to: 1-855-633-7673. It is not necessary to fax this cover page.

## **Information about this Request for Step Therapy Exception**

---

Use this form to request an exception to the plan step therapy requirement. Step therapy drugs are formulary drugs that are covered only if certain first-line formulary alternatives have been tried first. To process this request, documentation must be provided that Step 1 medications have been tried or are likely to cause adverse effects. Please provide clinical information or other evidence supporting medical necessity of the Step 2 drug, including previous drugs attempted for this patient's condition.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

Member privacy is important to us. Our employees are trained regarding the appropriate way to handle our members' private health information.

**CONFIDENTIALITY NOTICE:** This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

☐ Request Expedited Review

## Prescriber and Pharmacy Information

Name: _____		Name: _____	
Member ID: _____	Specialty: _____		
Medicare ID: _____	DEA: _____		
Date of Birth: ____/____/____ Sex: M / F (Circle One)	NPI: _____		
Address: _____	Address: _____		
City: _____	City: _____		
State: _____ Zip: _____	State: _____ Zip: _____		
Phone: _____	Phone: _____ Fax: _____		
Nursing Home Resident? YES / NO (Circle One)	Pharmacy Name: _____		
Home Care Patient? YES / NO (Circle One)	NCPDP: _____		
	NPI: _____		
	Phone: _____ Fax: _____		

### Information for Requested Drug

Drug Name: \_\_\_\_\_ Drug Requested: Brand / Generic (Circle One)  
 Strength: \_\_\_\_\_ Dosage: \_\_\_\_\_ 30 Day Qty. \_\_\_\_\_ Drug: Newly Prescribed / Refill (Circle One)  
 Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_ Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review time frame will seriously jeopardize the health of your patient. To request an expedited review, simply indicate at the top of this page.

**Medical Justification:** Please provide medical justification the step therapy exception request. Attach additional pages if necessary. If all prescription drug alternative(s) listed on the formulary and required to be used in accordance with step therapy requirements:

- ☐ Has/have been ineffective in the treatment of the enrollee's disease or medical condition OR, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is/are likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, please specify relevant prior treatment experience here.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- ☐ Has/have caused or, based on sound clinical evidence and medical and scientific evidence, is/are likely to cause an adverse reaction or other harm to the enrollee, please specify prior adverse effect history here.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- ☐ If no available formulary alternative(s) required to be used in accordance with step therapy requirements has/have been previously tried, please check this box.

I attest that the information provided on this form is true and accurate as of this date.

**Prescriber's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_