Prior Authorization for Non-Formulary or Step Therapy Medication

Use this form to request an exception to your Plan's Step Therapy or Drug Formulary requirements. Step therapy drugs are covered only if certain first-line alternatives have been tried first. To process this request, provide documentation that first-line medications have been tried or are likely to cause adverse effects. Please provide clinical information or other evidence supporting the medical necessity of the exception drug, including previous formulary drugs attempted for this patient's condition.

Expedited Request: You can make an expedited request by indicating this in the next column of this form. If you request an expedited review and sign the 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.

Expedited Review: **YES** ☐ **NO** ☐
Standard reviews will be completed in less than 72 hours. An expedited review is available if you certify that a standard review time frame will seriously jeopardize the health of your patient.

Patient Information (Please Print)

Patient Name: ____________________ Date: ____________________

Member ID Number: ____________________ Date of Birth: ____________________

Physician Information (Please Print)

Physician Name: ____________________

Physician Phone: ____________________ Physician Fax: ____________________

Drug Requested *(Strength and Regime)*: ____________________

Diagnosis and Description: ____________________

Previous Therapies Attempted *(WHAT specific therapies were attempted and WHEN and WHY were they discontinued?)*:

Explanation *(Please include whether or not this will be a trial or long-term therapy)*:

Participating Pharmacy *(if known)*: ____________________

Criteria for Request for Step Therapy or Drug Formulary Exception

Medical Justification: Please provide medical justification for the Step Therapy or Drug Formulary exception request. Attach additional pages if necessary.

I attest that all prescription drug alternatives listed on the formulary (and required to be used in accordance with step therapy): *Select below*

☐ **Were discontinued** due to lack of efficacy or effectiveness, diminished effect, or an adverse event. This justification also includes other prescription drugs in the same pharmacologic class or with the same mechanism of action as the prescription drug alternative. *Please explain:*

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☐ **Are not in the patient's best interest** because the drug is expected to cause a significant barrier to the patient's adherence or compliance with the plan of care; worsen a comorbid condition; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities. *Please explain:*

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☐ **Are contraindicated** or will likely cause an adverse reaction or physical or mental harm to the patient. *Please explain:*

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☐ **Are expected to be ineffective** based on both the patient's known clinical characteristics and the known characteristics of the drug, based on medical and scientific evidence. *Please explain:*

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I verify that the information provided on this form is true and accurate at this time. Date: ____________________

Prescriber's Signature: ____________________

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

PLEASE DIRECT QUESTIONS AND REQUESTS TO:

PHP Pharmacy Department | Attn: Prior Authorization for Medication
1700 Magnavox Way, Suite 201 | Fort Wayne, IN 46804
Phone: 260-432-6690 ext 339 | **Toll-Free:** 800-982-6257 | **Fax:** 260-436-4809