NON-FORMULARY AND STEP THERAPY EXCEPTION REQUEST FORM

1. Please specify the nature of your request by selecting one of the following options:

❑ **Step Therapy Exception** ❑ **Non-Formulary Exception**

2. FAX this completed form to (800)977-4170

OR Submit an electronic prior authorization request at https://www.covermymeds.com/main/prior-authorization-forms/

OR Mail requests to: Pharmacy Services PA Dept. | 5 River Park Place East, Suite 210 | Fresno, CA 93720

Ambetter plans in Washington State are issued by Coordinated Care Corporation.

I. Provider Information	**II. Member Information**
Prescriber name (print):	Member name:
Office contact name:	Identification number:
Group name:	Group number:
Fax:	Date of Birth:
Phone:	Medication allergies:

III. Drug Information

Drug name and strength:	Dosage form:	Dosage Interval (sig):	Qty per Day:
Diagnosis relevant to ***this*** request:			
Expected length of therapy:			

Medication History for this Diagnosis

A. Is member currently treated on this medication?

❑ yes; How Long?_____[go to item B] ❑ no [skip item B; go to item C]

B. Is this request for continuation of a previous approval from a prior health plan?

❑ yes [please provide documentation of approval, or valid claim history from last 90 days] ❑ no

C. Please indicate previous treatment and outcomes below.

Drug Name (include strength and dosage)	**Dates of Therapy**	**Reason for Discontinuation**
1		
2		
3		
4		

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. The Ambetter Formulary is available on the Ambetter website at www.ambetterhealth.com (search for your state to view your specific formulary document.)

IV. Additional Clinical Information

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Services and Ambetter will respond via fax or phone within 24 hours of receipt of all necessary information, except during weekends or holidays. Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Incomplete forms will delay processing. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)