Step Therapy Exception Request Form Instructions

This form is intended to request an exception to step therapy requirements. Supporting documentation is required and additional clinical criteria may apply. If you would like to submit a standard prior authorization request, please go to http://www.covermymeds.com/main/prior-authorization-forms/

1. Complete the Step Therapy Form by filling in all highlighted sections. **Incomplete forms will delay processing**.

    a. In section I, *Provider Information*, please ensure to include the prescriber's name, Provider NPI, and accurate fax and phone contact information.
        i. For medical benefit requests, please include requesting provider's TIN, and also, the NPI and TIN for the servicing facility or servicing provider.
    b. In section II, *Member Information*, please provide member's name, member ID, and date of birth. Please list relevant allergies, if any.
    c. In section III, *Drug Information*, please provide drug name, specific formulation (extended release, solution, etc.), the strength of the medication and the daily dose being requested.
        i. Please ensure a valid diagnosis is included in this section.
        ii. If member is already receiving this medication, please fill out the *Medication History for this Diagnosis* section in full. Please include any previous medications that have been tried and failed for this diagnosis.
    d. In section IV, *Additional Clinical Information,* please provide any additional information or details that are relevant to the request. Please include lab reports with request when appropriate. (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)

2. Submit the completed from through one of the following options:

    a. Fax the completed form to **(800) 977-4170**
    b. Or attach this form to an electronic prior authorization request at http://www.covermymeds.com/main/prior-authorization-forms/
    c. Or mail this form to: Centene Pharmacy Services – Coverage Determination; P.O Box 31397 Tampa, FL 33631-3397

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I. Provider Information		II. Member Information
Prescriber name (print):		Member name:
Requesting Provider NPI:	TIN:	Identification number:
Servicing Facility/Provider NPI:	TIN:	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:

Requests for step therapy exceptions 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.)

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