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| **Step Therapy Exemption Prior Authorization Form for Any Medical Condition** |
| **To file electronically, please fill out the form and submit to the Prior Authorization Mailbox utilizing this link:** **PriorAuthHPNSHLSHO@optum.com** | **To file via facsimile, send to 1-800-282-8845** |
| **To contact the coverage review team for your health plan please call the toll-free number on your medical ID card between the hours of 8am-5pm MST. For after-hours review, please call the number on your ID card.** |
| **(1) Priority and Frequency:**  | Click or tap here to enter text. |
| **a. Standard** |[ ]  **b. Urgent/Expedited** |[ ]
| **b. Urgent/Expedited** |[ ]  **Provider certifies that exigent circumstances exist in this case**  |
| **c. Frequency:** | **Initial:**  |[ ]  **Extension:** |[ ]  **Previous Authorization #:**  | Click or tap here to enter text. |
| **(2) Enrollee Information:**  | Click or tap here to enter text. |
| **a. Enrollee**  **Name:** | Click or tap here to enter text. | **b. Enrollee date**  **of birth:** | Click or tap here to enter text. | **c. Subscriber/**  **Member ID#:** | Click or tap here to enter text. |
| **d. Enrollee Street Address:**  | Click or tap here to enter text. |
| **e. City:** | Click or tap here to enter text. | **f. State:** | Click or tap here to enter text. | **g. Zip Code:** | Click or tap here to enter text. |
| **(3) Provider Information:**  | **Ordering Provider:** |[ ]  **Rendering Provider:** |[ ]  **Both** |[ ]
| **Step Therapy Exception Requests require the following information: progress notes, laboratory results, radiology results, previous medications, and other factors impacting the plan of care. Processing delays may occur if the requestor (e.g. rendering provider, ordering provider, or member) does not have appropriate documentation of medical necessity.** **Please note: Requests are reviewed by Registered Nurses, Pharmacists, and Board Certified Oncologists.** |
| **a. Provider Name:** | Click or tap here to enter text. | **b. Provider Type/Specialty** | Click or tap here to enter text. |
| **c. Administrative**  **Contact:** | Click or tap here to enter text. | **d. NPI #:**  | Click or tap here to enter text. | **e. DEA # (if**  **applicable)** | Click or tap here to enter text. |
| **f. Clinic/ Facility Name:** | Click or tap here to enter text. | **g. Clinic/Pharmacy** **Facility Street Address:**  | Click or tap here to enter text. |
| **h. City/State/Zip:** | Click or tap here to enter text. | **i. Phone Number/Extension** | Click or tap here to enter text. |
| **j. Facsimile/Email:**  | Click or tap here to enter text. |
| **k. Rationale for step-therapy exception request:** |
|[ ]  **Alternative drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure.** |
|  | **(a) Each prescription drug that is required to be used earlier in the step therapy protocol:*** 1. **(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;**
	2. **(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;**
	3. **(3) Has been tried by the insured, regardless of whether the insured was covered by the current benefit contract at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or**
	4. **(4) Is not in the best interest of the insured, based on medical necessity; or**

**(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current benefit contract at the time the attending practitioner selected the drug.** | Click or tap here to enter text. |
|[ ]  **Patient is stable on current drug(s), high risk of significant adverse clinical outcome with medication change.** |
|  | **Specify anticipated significant adverse clinical outcome:** | Click or tap here to enter text. |
|[ ]  **Medical need for different dosage and/or higher dosage.** |
|  | **Specify: (1) Dosage(s) tried; (2) Explain medical reason:**  | Click or tap here to enter text. |
|[ ]  **Request for Step Therapy Exemption. Please specify:** |
|  | Click or tap here to enter text. |
|[ ]  **Other. Please Explain:** | Click or tap here to enter text. |
| **l. List any other medications patient will use in combination with requested medication:** |
| Click or tap here to enter text. |
| **m. List any known drug allergies:** | Click or tap here to enter text. |
| **(9) Previous services/therapy (including drug, dose, durations, and reason for discontinuing each previous service/therapy)?** |
| **a.** | Click or tap here to enter text. | **Date Discontinued:**  | Click or tap here to enter text. |
| **b.** | Click or tap here to enter text. | **Date Discontinued:**  | Click or tap here to enter text. |
| **c.** | Click or tap here to enter text. | **Date Discontinued:**  | Click or tap here to enter text. |
| **(10) Attestation:**  **I hereby certify and attest that all information provided as part of this prior authorization is true and accurate.** |
| **Requester Signature:**  | Click or tap here to enter text. | **Date:**  | Click or tap here to enter text. |
| **Please note: Oncology Exception requests are limited to members with stage 3 or stage 4 cancer.** |
| **DO NOT WRITE BELOW THIS LINE. FIELDS TO BE COMPLETED BY PLAN.** |
| **Authorization #:**  | Click or tap here to enter text. | **Contact Name:**  | Click or tap here to enter text. |
| **Contact’s credentials/designation:**  | Click or tap here to enter text. |