oklahoma complete health

# Step Therapy Exception Request Form

☐ Non-Urgent
☐ Expedited

**CoverMyMeds** is the preferred way to submit prior authorizations. **https://www.covermymeds.com/main/prior-authorization-forms/**
If a step therapy exception is needed, please complete below and **FAX** completed form to 1-844-235-5092
**OR** MAIL requests to: Centene Pharmacy Services Coverage Determinations| P.O. Box 31397 |Tampa, FL 33631-3397
**Contacts:** 1-833-331-1515 (SoonerSelect) or 1-833-655-0896 (SoonerSelect Children's Specialty Program)

| I. PRESCRIBER INFORMATION | II. MEMBER INFORMATION | | |
|---|---|---|---|
| Prescriber Name: | Member name: | | |
| Prescriber Specialty: | Member ID# | | |
| Prescriber NPI: | Date of Birth: | | |
| Prescriber Fax: | Gender: | Height: | Weight: |
| Prescriber Phone: | Allergies: | | |

| III. DRUG INFORMATION (One drug request per form) | | | |
|---|---|---|---|
| Drug name: | Drug Strength: | NDC or HCPCS code: | |
| Regimen: | Route of Administration: | Administration Location: | |
| Fill Date: | Fill Quantity: | Day Supply: | Refills: |
| Indication/Diagnosis: | | ICD-10: | |

| IV. BILLING PROVIDER INFORMATION | |
|---|---|
| ☐ **Physician Billing (HCPCS code: ________________)** | ☐ **Pharmacy Billing (NDC:____________________)** |
| **Provider NPI:** | **Provider Name:** |
| **Provider Phone:** | **Provider Fax:** |

**V. RATIONALE FOR EXCEPTION REQUEST (Please select at least one of the following six reasons for exception).**

Compliance with the prior authorization process is a condition for payment by SoonerSelect. Step therapy exception requests do not negate clinical prior authorization criteria requirements. All information must be provided and SoonerSelect may verify through further requested documentation. The member's drug history will be reviewed prior to approval. If the member received medications other than through SoonerSelect, please submit pharmacy records along with the prior authorization form.

Type of Request: ☐ New Therapy ☐ Renewal (if renewal answer questions below)

**If renewal**: How did the member receive the medication?
Paid Under Insurance: ________________ Prior Authorization #: ________________
Other (Please explain): ____________________________________________

**Please indicate the rationale for step therapy exception in accordance with OK Statute Section 7310 of Title 63**:

☐ **Required drug trial(s) are contraindicated.** Documentation from the package insert regarding contraindication must be submitted. Specify details in following boxes (e.g., disease state, organ dysfunction, concurrent therapy, allergy):

- Diagnoses for Contraindication (include dates):
- Concurrent Therapies (medication, dose, start date, end date, duration):
- Allergies (specify nature of allergy and date):

oklahoma complete health

# Step Therapy Exception Request Form (continued)

| Member Name: | Date of Birth: | Member ID: |
|---|---|---|

## V. RATIONALE FOR EXCEPTION REQUEST (continued)

Compliance with the prior authorization process is a condition for payment by SoonerSelect. Step therapy exception requests do not negate clinical prior authorization criteria requirements. All information must be provided and SoonerSelect may verify through further requested documentation. The member's drug history will be reviewed prior to approval. If the member received medications other than through SoonerSelect, please submit pharmacy records along with the prior authorization form.

**Please indicate the rationale for step therapy exception in accordance with OK Statute Section 7310 of Title 63**:

☐ **Required drug trial(s) are likely to cause an adverse event.** Documentation of FDA MedWatch form and documentation of adverse drug reaction(s) must be submitted. Specify details in following boxes [e.g., history of adverse events associated with required drug trial(s), clinical condition that makes required drug trial(s) inappropriate]:

- History of adverse event associated with required drug trial(s) (medication, dose, start date, end date, duration, nature of adverse event):
- Clinical condition that makes required drug trial(s) inappropriate (condition, dates):

☐ **Required drug trial(s) are expected to be ineffective.** If yes, specify details.

- Previous trial was ineffective. Medication dates, duration, doses, and response/reason for failure must be listed:
- Other (detailed clinical information must be provided):

☐ **Member has tried required drug trial(s) through other health insurance.** If yes, specify details.

- Medication dates, duration, doses, and response/reason for failure must be listed:

☐ **Required drug trial(s) are not in the best interest of the member based on medical necessity.** If yes, specific details regarding why selected medication is superior to required drug trial(s) must be provided:

- Specific details regarding why selected medication is superior to required drug trial(s) must be provided:

☐ **Member is stable on requested medication.** If yes, provide specific details:

- Medication dates, duration, doses and most recent fill date/day supply, and method via which the medication was obtained (e.g., other insurance) must be listed:

The above format is to assist the prescriber to provide medical documentation that SoonerSelect needs to review this request.

| Provider Signature: | Date Signed: |
|---|---|

By signature, the physician confirms the criteria information above is accurate and verifiable in patient records. Specific information/ documentation will be requested if necessary. Failure to complete this form in full will result in processing delays and shall not be considered.