

**To:** Click or tap here to enter recipient name  
**From:** Click or tap here to enter contact name  
**Phone #:** Click or tap here to enter contact phone number  
**Fax #:** Click or tap here to enter contact fax number  
**# Of Pages:** Click or tap here to enter number of pages



## Step Therapy Exemption Form

### Instructions

- Please complete the attached "Request for Step Therapy Exemption" form
- To prevent delays in the review process, please complete all requested fields
- Health Care Providers requesting step therapy exemption: Please complete pages 2 and 3
- Members requesting step therapy exemption: Please complete page 4
- Fax completed form to **1-888-656-6671**.

### Important Information About Medical Pharmacy Prescription Drug Coverage and this Request for Step Therapy Exemption

Use this form to request an exemption to the plan's step therapy requirement. Step therapy drugs are formulary drugs that are covered only if certain first-line formulary alternatives have already been tried.

To process this request, documentation must be provided to indicate that first-line formulary medications have been tried or are likely to cause adverse effects. Please provide clinical information or other evidence supporting medical necessity of the requested medication, including previous drugs attempted for this patient's condition.

## Health Care Provider Protocol Exemption Request Form

To prescribe a medication, medical procedure, or course of treatment for a condition that is different from the step-therapy protocol developed within the members health plan policy, complete this Provider Protocol Exemption Form. Health care providers only please complete the entire form in accordance with the instructions contained below on pages 2 and 3.

### Member Information

<b>Member Name:</b> Click or tap here to enter patient's name
<b>Member ID:</b> Click or tap here to enter patient's member ID
<b>Health Plan:</b> Click or tap here to enter patient's health plan
<b>Date of Birth:</b> Click or tap here to enter patient's date of birth
<b>Address:</b> Click or tap here to enter patient's street address
<b>City/State/Zip Code:</b> Click or tap here to enter provider's city, state, zip code
<b>Phone Number:</b> Click or tap here to enter patient's phone number

### Prescriber Information

<b>Prescriber Name:</b> Click or tap here to enter provider's name
<b>Specialty:</b> Click or tap here to enter provider's specialty
<b>NPI:</b> Click or tap here to enter provider's NPI
<b>TIN:</b> Click or tap here to enter provider's TIN
<b>Practice Address:</b> Click or tap here to enter provider's address
<b>City/State/Zip Code:</b> Click or tap here to enter provider's city, state, zip code
<b>Prescriber Phone Number:</b> Click or tap here to enter provider's phone number
<b>Prescriber Fax Number:</b> Click or tap here to enter provider's fax number

### Request Information

<b>Medication Name:</b> Click or tap here to enter medication name
<b>Diagnosis:</b> Click or tap here to enter the diagnosis code
<b>Dose &amp; Frequency:</b> Click or tap here to enter the dose and frequency
<b>Please Indicate:</b> New Therapy <input type="checkbox"/> <b>or</b> Continuation of Therapy <input type="checkbox"/>
<b>Expedited Request*</b> Yes <input type="checkbox"/> No <input type="checkbox"/> (Standard reviews will be completed in accordance with state statutes on Step Therapy exemptions. If you request an expedited review and sign the attached form, you certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.)

**Prime Therapeutics Management Use Only:**  
Please Follow Protocol for Step Therapy Exemptions

## Request for Step Therapy Exemption Criteria Medical Justification

Please provide medical justification for the step therapy exemption request in the box below. Attach additional pages if necessary. If all prescription drug alternative(s) listed on the formulary and required to be used in accordance with step therapy requirements has/have been ineffective in the treatment of the enrollee's disease or medical condition **OR**, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is/are likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, **OR** has/have caused, or, based on sound clinical evidence and medical and scientific evidence, is/are likely to cause an adverse reaction or other harm to the enrollee please specify relevant prior treatment experience here:

Click or tap here to enter relevant clinical information supporting whether step therapy requirements has/have caused, or, based on sound clinical evidence and medical and scientific evidence, is/are likely to cause an adverse reaction or other harm to the enrollee.

If no available formulary alternative(s) required to be used in accordance with step therapy requirements has/have been previously tried, please check this box: ☐

**I attest that the information provided on this form is true and accurate as of this date:**

\_\_\_\_\_  
**Prescriber's signature**

\_\_\_\_\_  
**Date**

**Supporting Documentation:** ALL medical documentation related to the request **must** accompany this form (i.e., medical records, operative report, etc.)

**\*\*Please note:** Effective immediately, the related medical documentation must be submitted with the request, or it will not be considered a valid request.

**CONFIDENTIALITY NOTICE:** This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Member privacy is important to us. Our employees are trained regarding the appropriate way to handle our members' private health information. **Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

**Prime Therapeutics Management Use Only:**  
Please Follow Protocol for Step Therapy Exemptions

## Member Step Therapy Protocol Exemption Request Form (Patient form only)

I understand that for Prime Therapeutics Management to review my request, they may need health records. I allow persons or entities that have any medical records to release such information. I allow any other knowledge of me or my dependents to release such information to Prime Therapeutics Management. This allows Prime Therapeutics Management to complete the review of my exemption request.

### Member Information

<b>Member Name:</b> Click or tap here to enter patient's name
<b>Member ID:</b> Click or tap here to enter patient's member ID
<b>Health Plan:</b> Click or tap here to enter patient's health plan
<b>Date of Birth:</b> Click or tap here to enter patient's date of birth
<b>Address:</b> Click or tap here to enter patient's street address
<b>City/State/Zip Code:</b> Click or tap here to enter provider's city, state, zip code
<b>Phone Number:</b> Click or tap here to enter patient's phone number

### Request Information

<b>Medication Name:</b> Click or tap here to enter medication name
<b>Diagnosis:</b> Click or tap here to enter the diagnosis code
<b>Dose &amp; Frequency:</b> Click or tap here to enter the dose and frequency
<b>Please Indicate:</b> New Therapy <input type="checkbox"/> <b>or</b> Continuation of Therapy <input type="checkbox"/>
<b>Expedited Request*</b> Yes <input type="checkbox"/> No <input type="checkbox"/> (Standard reviews will be completed in accordance with state statutes on Step Therapy exemptions. If you request an expedited review and sign the attached form, you certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.)

## Request for Step Therapy Exemption Criteria Medical Justification:

Please provide in detail why a step therapy protocol exemption should be allowed. (Why the member should not follow the current health plan policy. The health plan requires the order in which certain prescription drugs, medical procedure, or course of treatment are required.) Supportive documentation is required. Use additional sheet(s) if necessary.

Click or tap here to enter relevant clinical information supporting whether step therapy requirements has/have caused, or, based on sound clinical evidence and medical and scientific evidence, is/are likely to cause an adverse reaction or other harm to the enrollee.

I attest that the information provided on this form is true and accurate as of this date:

\_\_\_\_\_  
Patient or Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

**Prime Therapeutics Management Use Only:**  
Please Follow Protocol for Step Therapy Exemptions