Request for Step Therapy Evaluation

TO CALL THIS INFORMATION INTO THE PHARMACY HELP DESK DIRECTLY
PHONE # 1-800-499-1275
FAX # 1-800-956-2397

Patient Name: (Please Print)	
Patient ID Number:	**Patient Birthdate:**
MD Name:	**MD Specialty:**
MD Phone #:	**MD Fax #:**
MD NPI#	

____ Pursuant to Insurance Law Section 4903 (c-2) and Public Health Law Section 4903 (3-b), I hereby request a determination within 24 hours because the request is for a patient witha medical condition that places the health of my patient in serious jeopardy without the prescription drug or drugs I am prescribing for my patient.

Requested Drug Name: _____

Quantity and Dosing Instructions: _____

Diagnosis: _____

☐ New Start ☐ Continued Therapy Start Date:_____

Please list previous therapies that the patient has attempted and their outcomes:

Drug Name_____Dates of Use____to____Outcome_____

Drug Name_____Dates of Use____to____Outcome_____

Drug Name_____Dates of Use to Outcome_____

STEP THERAPY PROTOCOL OVERRIDE DETERMINATION REQUEST PURSUANT TO INSURANCE LAW 4903 (Does Not Apply to Self-Funded Plans)

Please note: if you are requesting a step therapy override, you MUST attach supporting rationale and documentation to support your request

I am making this request for a step therapy override because the prescription drug or drugs required by the health plan:

____Is/are contraindicated or will likely cause an adverse reaction by physical or mental harm to the patient;

____Is/are expected to be ineffective based on the known clinical history and conditions of the patient and his/her prescription drug regimen;

(Continued on the following page)

____Has/have been tried by the patient or another prescription drug(s) in the same pharmacologic class or with the same mechanism of action and such prescription drug(s) was discontinued due to a lack of efficacy or effectiveness, diminished effect or an adverse event;

____Should not be required because the patient is stable on another prescription drug selected by their health care professional for the medical condition under consideration;

____Is/are not in the best interest of the patient because it will likely cause a significant barrier to a patient's adherence with his/her plan of care, will likely worsen a comorbid condition of the patient, or will likely decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

Rationale for the request:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I certify that the above information is true and accurate to the best of my knowledge.

Please add your electronic signature below or print this document and provide your handwritten signature to avoid delays.

Provider Signature:_____Date: _____