# Oncology Step Therapy Exception Prior Authorization Form

| | |
|---|---|
| **To file electronically, attach to request submitted in web portal.** | **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** | ☐ | **Services scheduled for this date:** | Click or tap here to enter text. | | | | |
| **b. Urgent/Expedited** | ☐ | **Provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the enrollee.** | | | | | |
| **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** | ☐ | |

**Please note: Exception requests are to be submitted under urgent status through phone, fax, or web portal. Step therapy Exception requests are limited to members with stage 3 or stage 4 cancer and 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. | | | | |

**(4) Requested medical or behavioral health course of treatment/procedure/device information (skip to Section 8 if requesting a drug).**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **a. Service Description:** | Click or tap here to enter text. | | | | | | | | | | |
| **b. Setting/CMS POS Code:** | **Outpatient:** | ☐ | **Inpatient:** | ☐ | **Home:** | ☐ | **Office:** | ☐ | **Other*:** | ☐ | |
| **c. *Please specify if other:** | Click or tap here to enter text. | | | | | | | | | | |

**(5) HCPCS/CPT/ICD-10 CODES:**

| a. Latest ICD-10 Code | b. HCPCS/CPT/CDT Code | c. Medical Reason |
|---|---|---|
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

| | | |
|---|---|---|
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **(6) Frequency/Quantity/Repetition Request:** | Click or tap here to enter text. | | | | | | | | |
| **a. Does this service involve multiple treatments?** | **Yes:** | ☐ | **No:** | ☐ | **If "No," skip to Section 7.** | | | | |
| **b. Type of Service:** | Click or tap here to enter text. | **c. Name of Therapy/Agency:** | Click or tap here to enter text. | | | | | | |
| **d. Units/Volume/Visits Requested:** | Click or tap here to enter text. | **e. Frequency/Length of Time Needed:** | Click or tap here to enter text. | | | | | | |
| **(8) Prescription Drug:** | Click or tap here to enter text. | | | | | | | | |
| **a. Diagnosis Name and Code:** | Click or tap here to enter text. | | | | | | | | |
| **b. Patient Height (if required):** | Click or tap here to enter text. | **c. Patient Weight (if required):** | Click or tap here to enter text. | | | | | | |
| **d. Route of Administration:** | **Oral/SL:** | ☐ | **Topical:** | ☐ | **Injection:** | ☐ | **IV:** | ☐ | **Other*:** ☐ |
| ***Please explain if "other:"** | Click or tap here to enter text. | | | | | | | | |
| **e. Administrated:** | **Doctor's Office:** | ☐ | **Dialysis Center:** | ☐ | **Home Health Hospice:** | ☐ | **By Patient:** | ☐ | |

| **f. Medication Requested** | **g. Strength (include both loading and maintenance dosage)** | **h. Dosing Schedule (including length of therapy)** | **i. Quantity per month or Quantity Limits** |
|---|---|---|---|
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

| | | | | | |
|---|---|---|---|---|---|
| **j. Is the patient currently treated with the requested medication(s):** | **Yes*:** | ☐ | **No:** | ☐ | |
| ***If "Yes," when was the treatment with the requested medication started? Date:** | Click or tap here to enter text. | | | | |
| **k. Anticipated medication start date (MM/DD/YY):** | Click or tap here to enter text. | | | | |

| | |
|---|---|
| **l. General prior authorization request. Explain the clinical reason(s) for the requested medications, including an explanation for selecting these medications over alternatives:** | |
| Click or tap here to enter text. | |
| **m. Rationale for drug formulary or step-therapy exception request:** | |
| ☐ | **Alternative drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure.** |
| | **Please specify:**<br>**(1) Drug(s) contraindicated or tried;**<br>**(2) Adverse outcome for each;**<br>**(3) If therapeutic failure, length of therapy on each drug(s).** — 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 formulary exception. Please specify:** |

| | | |
|---|---|---|
| | **(1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug;**<br>**(2) If therapeutic failure, length of therapy on each drug and adverse outcome;**<br>**(3) If not as effective, length of therapy on each drug and outcome.** | Click or tap here to enter text. |
| ☐ | **Other. Please Explain:** | Click or tap here to enter text. |

| | | | |
|---|---|---|---|
| **n. List any other medications patient will use in combination with requested medication:** | | | |
| Click or tap here to enter text. | | | |
| **o. 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. |

**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. | | |