PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Step Therapy Exception Form

SERVE YOU Rx

Phone: 800-759-3203 Fax back to: 800-480-4840

Serve You Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Plan Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty:	

Drug Name and Strength: ☐ Urgent Review Requested

Directions:

Expected Duration of Therapy:

If this is a continuation of therapy, provide start date:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Diagnosis:

Q2. Diagnosis code (ICD):

Q3. Is the patient stable on the requested drug (e.g., continuation of therapy)?

☐ Yes ☐ No

Q4. Please indicate start date:

Q5. Is the patient currently receiving pharmaceutical samples of the requested drug?

☐ Yes ☐ No

Q6. Is the patient currently obtaining the requested drug through manufacturer coupon cards?

☐ Yes ☐ No

Q7. Has the patient tried and failed another drug in the same pharmacologic class or with the same mechanism of action as the requested drug?

☐ Yes ☐ No

Q8. Please list all medications previously tried and failed for the treatment of this diagnosis. Please include reason(s) for discontinuation, if applicable.

☐ Medication #1
☐ Medication #2

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☐ Medication #3
☐ Medication #4

Q9. Is the prerequisite drug(s) [i.e., required drug(s) under step therapy] contraindicated?

☐ Yes ☐ No

Q10. If yes, please describe contraindication(s):

Q11. Is the prequisite drug(s) expected to cause any of the following (please check those that apply):

☐ A serious adverse reaction to the patient
☐ A decrease in the ability to achieve or maintain reasonable functional ability in performing daily activities
☐ Physical or psychiatric harm to the patient

Q12. Is the prerequisite drug(s) expected to be ineffective?

☐ Yes ☐ No

Q13. If yes, please describe:

Q14. Additional comments: (Note: The step therapy exceptions review process incorporates all relevant state mandates.)

Prescriber Signature _____ Date _____

Certain prescription benefit plans or situations may require additional information or clarification to evaluate a prior authorization request. For complete details about benefits, limitations, conditions and exclusions, please refer to the applicable plan.