Prior Authorization Request

EOC: Step Therapy Exception Form

ServeYou Rx

Serve You Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Fill out electronically, or print using blue or black ink. If you have questions or need additional forms, visit ServeYouRx.com or call 800-759-3203.

Fax completed form to: 800-480-4840, Attn: Authorizations **Note:** Blank fields or illegible responses may delay the review process.

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Member ID #: _____ Group #: _____

Permanent Address: _____ City: _____ State: _____ ZIP: _____

Primary Phone #: _____ ☐ Mobile ☐ Work ☐ Home

Secondary Phone #: _____ ☐ Mobile ☐ Work ☐ Home

PRESCRIBER INFORMATION

Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ ZIP: _____

NPI: _____ State License ID: _____

Office Contact: _____ Fax: _____ Phone: _____

REQUESTED MEDICATION

Drug Name: _____ Strength: _____ Frequency: _____

Directions: _____

Expected Duration of Therapy: _____ If this is a continuation of therapy, provide start date: _____

☐ **Pertinent medical history or information for this patient is attached that may support approval**

☐ **Urgent review requested**

REQUIRED INFORMATION

1 Diagnosis:

2 Diagnosis code (ICD): _____

3 Is the patient stable on the requested drug (e.g., continuation of therapy)?
☐ Yes ☐ No

4 **If yes to above:** Please indicate start date: _____

5 Is the patient currently receiving pharmaceutical samples of the requested drug?
☐ Yes ☐ No

6 Is the patient currently obtaining the requested drug through manufacturer coupon cards?
☐ Yes ☐ No

7 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

8 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 _____

☐ Medication #3 _____

☐ Medication #4 _____

9 Is the prerequisite drug(s) [i.e., required drug(s) under step therapy] contraindicated?
☐ Yes ☐ No

10 **If yes to above:** Please describe contraindication(s):

11 Is the prerequisite 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

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12 Is the prerequisite drug(s) expected to be ineffective?
☐ Yes ☐ No

13 **If yes to above:** Please describe:

14 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.