Minnesota Step Therapy Exception Request

Prior Authorization Request

Please respond below and fax the completed form to CVS Caremark at 1-888-836-0730.

The member's prescription benefit plan may request additional information or clarification, if needed, to evaluate requests.

Patient's Name: _____ **Date**: _____

Patient's ID: _____ **Patient's Date of Birth:** _____

Physician's Name: _____

Specialty: _____ **NPI#:** _____

Physician Office Telephone: _____ **Physician Office Fax:** _____

Request Initiated For: _____

1. What drug is being prescribed? _____
2. What is the patient's diagnosis? _____
3. What is the ICD-10 code? _____
4. Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No
5. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No
6. Is the preferred drug contraindicated for the patient? *If Yes, no further questions* ❑ Yes ❑ No
7. Has the patient experienced a documented adverse event while taking the preferred drug? *If Yes, no further questions* ❑ Yes ❑ No
8. Is the preferred drug likely to cause an adverse reaction, decrease the ability of the patient to achieve or maintain reasonable functional ability in performing daily activities, or cause physical or mental harm to the patient? *If Yes, no further questions* ❑ Yes ❑ No
9. Has the patient tried the preferred drug or another prescription drug in the same drug class or with the same mechanism of action for a sufficient period of time to allow for a positive treatment outcome and was it discontinued due to lack of effectiveness or an adverse event? *If Yes, no further questions* ❑ Yes ❑ No *(Note: Pharmaceutical drug samples are not considered trial and failure of a preferred drug).*
10. Is the patient currently receiving the requested drug and the healthcare provider believes that changing to the preferred drug is expected to be ineffective or cause harm to the patient based on the known characteristics of the patient and the known characteristics of the preferred drug? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark, the benefit plan sponsor, or (if applicable) any state or federal regulatory agency.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: CVS Caremark Prior Authorization Fax: 1-888-836-0730