



Minnesota Step Therapy Exception Request

Prior Authorization Request

Please submit the prior authorization (PA) request electronically via ePA.

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)**
Please submit the prior authorization (PA) request electronically via ePA.

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Minnesota Step Therapy Exception Request SGM - 1/2019.

CVS Caremark Prior Authorization • 1300 E. Campbell Rd. • Richardson, TX 75081

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