MyTruAdvantage

Fax completed form to: 1-855-633-7673
Questions, please call: 1-855-344-0930
24 hours a day 7 days a week
TTY users call: 711

Important Information about Prescription Drug Coverage

To: From:

Fax: Pages:

Re: Request for Step Therapy Exception: Please Respond.

- Please complete the attached Request for Step Therapy Exception Form.
- To prevent delays in the review process please complete all requested fields.
- Completed forms should be faxed to: 812-378-7048. It is not necessary to fax this cover page.

Information about this Request for Step Therapy Exception

Use this form to request an exception to the plan step therapy requirement. Step therapy drugs are formulary drugs that are covered only if certain first-line formulary alternatives have been tried first. To process this request, documentation must be provided that Step 1 medications have been tried or are likely to cause adverse effects. Please provide clinical information or other evidence supporting medical necessity of the Step 2 drug, including previous drugs attempted for this patient's condition.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

MyTruAdvantage has HMO and PPO plans with a Medicare contract. Enrollment in MyTruAdvantage depends on contract renewal.

Member privacy is important to us. Our employees are trained regarding the appropriate way to handle our members' private health information.

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Request for Step Therapy Exception

☐ Request Expedited Review

Patient Information

Name: _____
Member ID: |__|__|__|__|__|__|__|__|__|__|
Medicare ID: |__|__|__|__|__|__|__|__|__|__|
Date of Birth: ____/____/_____ Sex: M / F (Circle One)
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____
Nursing Home Resident? YES / NO (Circle One)
Home Care Patient? YES / NO (Circle One)

Prescriber and Pharmacy Information

Name: _____
Specialty: _____
DEA: |__|__|__|__|__|__|__|__|__|
NPI: |__|__|__|__|__|__|__|__|__|__|
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____ Fax: _____
Pharmacy Name: _____
NCPDP: |__|__|__|__|__|__|__|
NPI: |__|__|__|__|__|__|__|__|__|__|
Phone: _____ Fax: _____

All items below this line are for Physician Use Only

Information for Requested Drug

Drug Name: _____ Drug Requested: Brand / Generic (Circle One)
Strength: _____ Dosage: _____ 30 Day Qty.____ Drug: Newly Prescribed / Refill (Circle One)
Directions: _____ Diagnosis: _____

ICD-10 Code: _____ Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review time frame will seriously jeopardize the health of your patient. To request an expedited review, simply indicate at the top of this page.

Request for Step Therapy Exception Criteria

Medical Justification: Please provide medical justification the step therapy exception request. Attach additional pages if necessary. If all prescription drug alternative(s) listed on the formulary and required to be used in accordance with step therapy requirements:

☐ Has/have been ineffective in the treatment of the enrollee's disease or medical condition OR, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is/are likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, please specify relevant prior treatment experience here.

_____
_____
_____

☐ Has/have caused or, based on sound clinical evidence and medical and scientific evidence, is/are likely to cause an adverse reaction or other harm to the enrollee, please specify prior adverse effect history here.

_____
_____
_____

☐ If no available formulary alternative(s) required to be used in accordance with step therapy requirements has/have been previously tried, please check this box.

I attest that the information provided on this form is true and accurate as of this date.

Prescriber's Signature _____ **Date:** _____