OHIO DEPARTMENT OF MEDICAID

STEP THERAPY EXEMPTION REQUEST

Request Date				Review Type Requested ☑ Standard ☐ Urgent	
Individual's Full Name				Prescriber's Full Name	
Individual's Date of Birth				Prescriber's NPI Number	
Individual's Medicaid ID Number				Prescriber's Address	
Age	Height	Weight	Sex	Prescriber's Phone Number	Prescriber's Fax Number
(If Known) Pharmacy's Name				Pharmacy's Phone Number	
Drug Requested		Strength		Route	
Frequency	Duration of Therapy	Quantity		☐ New ☐ Renewal	
Diagnosis and ICD-10 code **(MUST BE INCLUDED TO AVOID DELAYS)**					

RATIONALE FOR EXEMPTION REQUEST

1. Please indicate the rationale for Step Therapy Exemption in accordance with Ohio Rev. Code. § 5164.7514.

   ☐ Required prescription drug is contraindicated for the individual. **(Type I)**

   ☐ Required prescription drug was previously trialed while member was enrolled in other health care coverage. **(Type II)**

   ☐ The individual is stable on the prescribed drug for the medical condition. **(Type III)**

2. Please include the appropriate supporting documentation for your request based upon the nature of exemption requested. Refer to the table below for required documents.

FAILURE TO PROVIDE REQUESTED DOCUMENTATION WILL RESULT IN DENIED EXEMPTION REQUESTS

(Continued on Next Page)

Type	Exemption Description	Necessary Documentation

I	Required prescription drug is contraindicated for the individual.	• Documentation supporting required drug's contraindication (i.e., the drug's package insert)
		• Documentation supporting member has identified contraindication.
		  ○ If the contraindication is a disease state then diagnostic or other confirmatory test will need submitted.
		  ○ If contraindication is due to specific organ dysfunction then lab results demonstrating dysfunction will need submitted (test must be performed within prior 6 months with exceptions for genetic conditions or pregnancy).
		  ○ If contraindication is due to concurrent therapy then must address why modifications to the other agent cannot be made including documented consultation with provider of other agent as appropriate.
		  ○ If contraindication is due to an allergy, either direct or potentially associated, must provide complete history of previous allergic reaction inclusive of date of occurrence, type of reaction, and remedies taken.
		• Peer-reviewed medical literature supporting that the requested medication is medically necessary, safe, and effective for the individual's diagnosis if not used for a labeled indication, consistent with Medical or Scientific Evidence definition in Ohio Rev. Code. § 3922.01.
		  ○ Not required for drugs within the same Preferred Drug List (PDL) Categories.

II	Required prescription drug was previously trialed while the individual was enrolled in other health care coverage.	• Documentation supporting that the previous non-step therapy medication was trialed while enrolled with other health care coverage. ○ Certification from the prescriber requesting step therapy exemption will satisfy this requirement. **CONTINUED ON NEXT PAGE**

Type	Exemption Description	Necessary Documentation
		• Documentation supporting that the previous medication trial was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event. o Submitted documents must address the date and specific response, effect or event to therapy as well as demonstrate medication dose optimization for the disease state was considered as appropriate (i.e., lack of effectiveness was not a result of inadequate trial length or attempt to maximize dosage per the product's labeling). • Progress notes may positively satisfy this request provided they address the above.
III	The individual is stable on the prescribed drug for the medical condition.	• Documentation supporting that the current duration the requested medication has been used in the individual. o The medication has been utilized for 6 or more months. • Documentation supporting disease state improvement or stabilization since the requested medication was started. • Progress notes may positively satisfy this request.

Please provide any additional rationale to support your request.

☐ I attest that I am a member of the prescriber's staff in accordance with Ohio Administrative Code rule 5160-9-03, as applicable. Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

_____ _____

Prescriber's Signature (or staff of prescriber) Date

_____

IF a staff member is attesting, please print your name

Fax To: Ohio Department of Medicaid
Fax: (800) 396 – 4111 PA Helpdesk: (877) 518 – 1546
Hours: Monday – Friday 8:00 am – 8:00 pm EST