

OHIO DEPARTMENT OF MEDICAID STEP THERAPY EXEMPTION REQUEST

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|----------------------------|--------|--------------------------|------------------------|
| Request Date | | | |
| Patient Medicaid ID Number | | Prescriber's Full Name | |
| Patient Date of Birth | | NPI Number | |
| Patient's Full Name | | DEA Number | |
| Age | Height | Prescribers Address | |
| Weight | Sex | Prescribers Phone Number | Prescribers Fax Number |

| | | |
|---|-----------------------|------------|
| Pharmacy Name | Pharmacy Phone Number | |
| Pharmacy Fax Number | Provider Number | |
| Drug and Strength Requested | Quantity | Day Supply |
| Directions | | |
| Indication for Drug for patient (<i>i.e. Diagnosis Intended to Treat</i>) | | |

RATIONALE FOR EXEMPTION REQUEST

1. Please indicate the rationale for Step Therapy Exemption in accordance with 51 Ohio Rev. Code. § 5164.7514

- ☐ Required Prescription Drug is Contraindicated for the Patient **(Type I)**
- ☐ Required Prescription Drug was previously trialed while member was enrolled in other health care coverage (Type II)
- ☐ The Patient 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 AS REQUESTED WILL RESULT IN DENIED EXEMPTION REQUESTS
(Continued on Next Page)**

| Type | Exemption Description | Necessary Documentation |
|------|--|--|
| I | Required prescription drug is contraindicated for the Patient | <ul style="list-style-type: none"> • Documentation supporting required drug's contraindication (i.e. the drug's package insert) • Documentation supporting member has identified contraindication <ul style="list-style-type: none"> ○ 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 3 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. • Document supporting that the requested is appropriate for the indication consistent with Medical or Scientific Evidence definition in 39 Ohio Rev. Code. § 3922.01. <ul style="list-style-type: none"> ○ Not required for drugs within the same Preferred Drug List (PDL) Categories • The previous 3 office visit progress notes or the prior 3 months of office visits, whichever is greater |
| II | Required prescription drug was previously trialed while the patient was enrolled in other health care coverage | <ul style="list-style-type: none"> • Documentation supporting that the previous medication was trialed while enrolled with other health care coverage <ul style="list-style-type: none"> ○ A print out of medications dispensed by the pharmacy will satisfy this requirement. ○ If a print out is unavailable, contact information of the filling pharmacy for verification by the Ohio Department of Medicaid (or its designee) will satisfy the request if they can provide fill dates for the therapy in question. <p style="text-align: center;">CONTINUED ON NEXT PAGE</p> |

| Type | Exemption Description | Necessary Documentation |
|------|--|--|
| | | <ul style="list-style-type: none"> Documentation supporting that the previous medication trial was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event. <ul style="list-style-type: none"> 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 <u>may</u> positively satisfy this request provided they address the above. The previous 3 office visit progress notes or the prior 3 months of office visits, whichever is greater |
| III | The Patient is stable on the prescribed drug for the medical condition | <ul style="list-style-type: none"> Documentation supporting that the current duration the requested medication has been used in the patient <ul style="list-style-type: none"> A patient is not considered stable on therapy unless the medication has been utilized for 12 or more months Progress notes <u>may</u> positively satisfy this request. |

Please provide any additional rationale to support your request

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I attest that I am a member of the prescriber's staff in accordance with OAC 5160-9-03.

Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

Prescriber Signature (or staff of Prescriber & PRINTED name)

Date

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