Kentucky Step Therapy Exception Request

Please complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-888-836-0730**.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

What drug is being prescribed? _____
What is the patient's diagnosis? _____
What is the ICD-10 code? _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? ☐ Y ☐ N
   If Yes, then go to 2. If No, then no further questions.
2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature? ☐ Y ☐ N
   If Yes, then go to 3. If No, then no further questions.
3. Is the alternate drug contraindicated or will likely cause an adverse reaction by physical or mental harm to the patient? ☐ Y ☐ N
   If Yes, then no further questions. If No, then go to 4.
4. Is the alternate drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen? ☐ Y ☐ N
   If Yes, then no further questions. If No, then go to 5.
5. Is the alternate drug not in the best interest of the patient because it is expected to do any of the following: A) cause a significant barrier to adherence to or compliance with the plan of care, B) worsen a comorbid condition, C) decrease the ability to achieve or maintain reasonable functional ability in performing daily activities? ☐ Y ☐ N
   If Yes, then no further questions. If No, then go to 6.
6. Has the patient tried the alternate drug while under the current or a previous health insurance or health plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Y ☐ N
   If Yes, then no further questions. If No, then go to 7.
7. Is the patient stable on the requested drug for the condition under consideration while under a current or previous health plan? ☐ Y ☐ N
   No further questions

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or if applicable, a state or federal regulatory agency.

X _____

Prescriber (Or Authorized) Signature **Date (mm/dd/yyyy)**

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

CVS Caremark Prior Authorization ● 1300 E. Campbell Rd. ● Richardson, TX 75081
Fax: 1-888-836-0730 ● www.caremark.com