SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Step Therapy Exception Request Form

❑ Non-Urgent
❑ Expedited

Member Information

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Gender: _____ ***Height:*** _____ ***Weight:*** _____ ***Allergies:*** _____

Drug Information

Medication Name: _____ ***NDC or HCPCS Code:*** _____

Strength: _____ ***Regimen:*** _____ ***Route of Administration:*** _____

Fill Date: _____ ***Fill Quantity:*** _____ ***Day Supply:*** _____ ***Refills:*** _____

Administration Location (e.g., home, prescriber's office): _____

Indication for Drug for Member (i.e. diagnosis intended to treat): _____

ICD-10: _____

Billing Provider Information

❑ Physician billing (HCPCS code: _____) ❑ Pharmacy billing (NDC: _____)

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Rationale for Exception Request

Compliance with the prior authorization process is a condition for payment by SoonerCare. Step therapy exception requests do not negate clinical prior authorization criteria requirements. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval. If the member received medications other than through SoonerCare, please submit pharmacy records along with the prior authorization form.

Type of Request:

❑ New Therapy ❑ Renewal

If renewal: How did the member receive the medication?

❑ Paid Under Insurance (Name: _____ Prior Authorization #: _____)

❑ Other (Please explain: _____)

Please indicate the rationale for step therapy exception in accordance with Oklahoma Statute Section 7310 of Title 63:

❑ Required drug trial(s) are contraindicated. Documentation from the package insert regarding contraindication must be submitted. Specify details in following boxes (e.g., disease state, organ dysfunction, concurrent therapy, allergy):

Diagnoses for Contraindication (include dates):
Concurrent Therapies (medication, dose, start date, end date, duration):
Allergies (specify nature of allergy and date):

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 405-271-4147
Phone: 1-800-522-0114 Option 4

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Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____

Rationale for Exception Request Continued

Compliance with the prior authorization process is a condition for payment by SoonerCare. Step therapy exception requests do not negate clinical prior authorization criteria requirements. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval. If the member received medications other than through SoonerCare, please submit pharmacy records along with the prior authorization form.

Please indicate the rationale for step therapy exception in accordance with Oklahoma Statute Section 7310 of Title 63:

❑ Required drug trial(s) are likely to cause an adverse event. Documentation of FDA MedWatch form and documentation of adverse drug reaction(s) must be submitted. Specify details in following boxes [e.g., history of adverse events associated with required drug trial(s), clinical condition that makes required drug trial(s) inappropriate]:

History of adverse event associated with required drug trial(s) (medication, dose, start date, end date, duration, nature of adverse event):
Clinical condition that makes required drug trial(s) inappropriate (condition, dates):

❑ Required drug trial(s) are expected to be ineffective. If yes, specify details in following boxes.

Previous trial was ineffective. Medication dates, duration, doses, and response/reason for failure must be listed:
Other (detailed clinical information must be provided):

❑ Member has tried required drug trial(s) through other health insurance. If yes, specify details in following box:

Medication dates, duration, doses, and response/reason for failure must be listed:

❑ Required drug trial(s) are not in the best interest of the member based on medical necessity. If yes, specific details regarding why selected medication is superior to required drug trial(s) must be provided in following box:

Specific details regarding why selected medication is superior to required drug trial(s) must be provided:

❑ Member is stable on requested medication. If yes, specify details in following box:

Medication dates, duration, doses and most recent fill date/day supply, and method via which the medication was obtained (e.g., other insurance) must be listed:

The above format is to assist the physician to provide medical documentation that SoonerCare needs to review this request.

Prescriber Signature: _____ **Date:** _____

By signature, the physician confirms the criteria information above is accurate and verifiable in patient records. Specific information/ documentation will be requested if necessary. Failure to complete this form in full will result in processing delays and shall not be considered.

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