



# PRIOR AUTHORIZATION REQUEST

## GLOBAL STEP THERAPY

### Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

### Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

### Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

**SECTION A:** Please note that supporting clinical documentation is required for **ALL PA requests**. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the patient currently receiving the medication? [If no, skip to question 5.]	Yes	No
2	Is the requested medication being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? [If no, no further questions.]	Yes	No
3	Does the patient have a previously approved prior authorization on file with the current plan?	Yes	No

**If you have any questions, call:  
1-888-258-8250**

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[If no, skip to question 5.]

[NOTE: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]

4	Is the patient responding to therapy? [No further questions.]	Yes	No
5	Is the requested medication being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? [If no, no further questions.]	Yes	No
6	Is the dose of the requested medication appropriate, based on the patient's age and indication? [If no, no further questions.]	Yes	No
7	Did the patient experience intolerance, adverse side effect, or treatment failure to the preferred step-therapy medication?	Yes	No

**Please document the diagnoses, symptoms, and/or any other information important to this review:**

### **SECTION B:** Physician Signature

PHYSICIAN SIGNATURE

DATE

**FAX COMPLETED FORM TO: 1-833-896-0656**

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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