

## STEP THERAPY EXEMPTION REQUEST FORM SILVERSUMMIT HEALTHPLAN - NEVADA

Requests are limited to Stage III or IV cancer

This form is to be submitted in addition to the prior authorization request form either by web portal or fax Please provide any clinical documentation, progress notes, labs, radiology results related to supporting the request

\*\*Note to reviewer - all Nevada step therapy exemption forms are to be processed as urgent\*\*
Final determination of all applications will be performed by either a pharmacist, physician, or registered nurse

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I. ATTENDING PRACTITIONER INFORMATION		II.	II. MEMBER INFORMATION		
Prescriber name (print):		Ме	Member name:		
Office contact name:		Ide	Identification number:		
NPI:		Gro	Group number:		
Fax:		Da	Date of Birth:		
Phone:		Ме	Medication allergies:		
III. DRUG INFORMATION (One drug	request per fo	rm)			
Drug name and strength:	Dosage form:	Do	sage Interval (sig)	Qty per Day:	
Diagnosis relevant to <i>this</i> request:		•			
Expected length of therapy:					
Medication History for this Diagnosis					
A. Is member currently treated on this medication?  ☐ yes; How Long? [go to item B] ☐ no [skip item B; go to item C]					
B. Is this request for continuation of a previous approval?  ☐yes [go to item C] ☐ no [go to item C]					
C. Please indicate previous treatment and	l outcomes below	<b>'.</b>			
Drug Name (include strength and dosage) Dates of The		erapy	Reason for Discontinuation		
1					
2					
3					
NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception					
criteria. <b>SilverSummit HealthPlan Preferred Drug List (PDL)</b> is available on the <b>SilverSummit HealthPlan</b> website at www.SilverSummitHealthPlan.com.					
IV. RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION (Required for all Request)					
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Appropriate clinical information to support the request on the basis of medical necessity must be submitted.		Provid	er Signature:	Date:	

Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e. g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)