COLORADO
Department of Health Care Policy & Financing

Fax completed form and supporting documentation to 1-800-424-5881

Serious or Complex Medical Condition Step Therapy Exception Request form

COLORADO
Department of Health Care Policy & Financing

Phone: 1-800-424-5725 Fax: 1-800-424-5881 Request Date: ____ / ____ / ________

PATIENT INFORMATION

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: ___ – ___ – ____

PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

STREET ADDRESS:

CITY: STATE: ZIP:

PHONE NUMBER: ___ – ___ – ____

FAX NUMBER: ___ – ___ – ____

NPI NUMBER:

DEA NUMBER: ___ – _______

DRUG INFORMATION

DRUG REQUESTED:

STRENGTH: ____________ QUANTITY: ____________ FREQUENCY OF DOSING: ____________

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Serious or Complex Medical Condition Step Therapy Exception Request form

For a Serious or Complex Medical Condition Step Therapy Exception request, a provider must answer the following:

1. Check one of the following boxes to indicate the member's diagnosis **and** attach supporting chart documentation:
   - ☐ Serious Mental Illness (*defined as bipolar disorders, depression in childhood and adolescence, major depressive disorders, obsessive-compulsive disorders, paranoid and other psychotic disorders, schizoaffective disorders, and schizophrenia*)
   - ☐ Cancer
   - ☐ Epilepsy
   - ☐ Multiple Sclerosis
   - ☐ HIV/AIDS
   - ☐ A condition requiring medical treatment to avoid death, hospitalization, or a worsening or advancing disease progression resulting in significant harm or disability. If selecting this option, add the diagnosis below:

   ____

2. Check one of the following boxes to indicate the medical justification for the step therapy exception request **and** attach supporting chart documentation:
   - ☐ The provider attests that the required prescription drug is contraindicated, or will likely cause intolerable side effects, a significant drug-drug interaction, or an allergic reaction to the recipient.
   - ☐ The required prescription drug lacks efficacy based on the known clinical characteristics of the recipient and the known characteristics of the prescription drug regimen.
   - ☐ The recipient has tried the required prescription drug, and the use of the prescription drug by the recipient was discontinued due to intolerable side effects, a significant drug-drug interaction, or an allergic reaction.
   - ☐ The recipient is stable on the prescription drug selected by the prescribing provider for the medical condition.

WHERE WILL MEDICATION BE ADMINISTERED? (CHECK ONE):

☐ Client's Home ☐ Long-Term Care Facility ☐ Dr.'s Office ☐ Dialysis Unit or Hospital

Requests that do not include the required information will experience a delay in the approval process.

____ _____________________

Prescriber Signature (Required) ***Date***

(By signature, the Prescriber confirms the criteria information above is accurate and verifiable in patient records)

<u>This form may be faxed or called in only:</u>
COLORADO MEDICAID PRIOR AUTHORIZATIONS
FAX NUMBER: 1-800-424-5881
PA HELP DESK: 1-800-424-5725