STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

STEP THERAPY PA REQUEST FORM - Proton Pump Inhibitors, Statins, Anti-migraine, Topical Acne Agents and Cytokine & CAM Antagonists

[This and other pharmacy PA forms are available at www.ctdssmap.com and can be accessed by clicking on the pharmacy icon]

PA Criteria for Step Therapy Drug Products

- The Pharmacy team will validate the client's history for the use of preferred agent(s) before approving a non-preferred agent. Non-Preferred drug approvals require documented evidence that the patient has tried and failed, is intolerant to, or has a contraindication to a normal course of therapy with at least one preferred drug in the class.
- For clients new to Medicaid, a pharmacy profile history showing previously failed preferred products, outcomes and compliance with the medication regimen length shall be provided with the non-preferred product request form.
- Clinical prior authorization must be obtained for any non-preferred step therapy drug **using this form only, not the standard drug PA form.**
- A copy of your filed FDA 3500 Med Watch Form is required if patients have experienced significant adverse effect

Prescriber and Member Information

Please Print: **Note - Incomplete requests will not be granted.**

1. Prescriber's Name (Last, First)	5. Member's Name (Last, First)
2. Prescriber's NPI	6. Member's ID
3. Prescriber's Phone	7. Member's Date of Birth (MM/DD/CCYY)
4. Prescriber's Fax	8. Pharmacy Name & Fax
9. Drug & Dosage Form (print)	
10. Route ☐ Oral ☐ Topical ☐ Inhalation ☐ Injectable	
11. Strength 12. Quantity 13. Frequency of Dosing	

Medical History

Note - Incomplete requests will be denied.

Please explain why the patient cannot be treated with a preferred alternative. You MUST indicate which preferred product has been utilized in the past, circle a reason for the failure (listed below), AND supply a specific written clinical explanation.

14. Preferred Product Trial (Name & Daily Dose)	15. Reason	16. Clinical Explanation (including length of therapy, date commenced, and outcome)
	1 2 3 4	

1. Use of the preferred alternative is contraindicated.
2. The patient has experienced significant adverse effects from the preferred alternative, Completed FDA 3500 MedWatch form attached and filed with the FDA.
3. Use of the preferred alternative has resulted in therapeutic failure after the normal course of treatment.
4. Pediatric patient (younger than 12 years of age).

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under Connecticut Gen. Stat. Section 17b-99 and Regulations of Conn. State Agencies Sections 17-83k-1-3 and 4a –7, inclusive. I certify that this member is under my clinic's/practice's ongoing care.

17. Signature of Prescriber* _____ 18. Date (MM/DD/CCYY) _____

*** Mandatory (others may not sign for prescriber)** In accordance with mandates set forth in the Affordable Care Act (ACA), providers who order, prescribe, or refer clients for services must be enrolled in the Connecticut Medical Assistance Program (CMAP). Effective 10/1/2013, any prescriptions or services provided by a non-enrolled provider shall no longer be considered/covered by CMAP.

(Direction Sheet) Informational Only

No.	Name	Description
1.	Prescriber's Name (Last, First)	Enter the prescribing practitioner's last name and first name
2.	Prescriber's NPI	Enter the prescribing practitioner's National Provider Identification (NPI) number
3.	Prescriber's Phone	Enter the prescribing practitioner's phone number where a PA customer service representative can contact the practitioner for additional information or clarification, if necessary
4.	Prescriber's Fax	Enter the prescribing practitioner's fax number where a PA customer service representative can contact the practitioner for additional information or clarification, if necessary
5.	Member's Name (Last, First)	Enter the member's name as it appears on the member's CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS)
6.	Member's ID	Enter the member's 9-digit identification number as it appears on the member's CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS)
7.	Member's Date of Birth (MMDDCCYY)	Enter the member's date of birth in MM/DD/CCYY format
8.	Pharmacy's Name & Fax (optional)	Enter the pharmacy's name and fax number, if known
9.	Drug & Dosage Form	Print the drug info for which the Prior Authorization is being requested
10.	Route	Select the route of the drug being requested
11.	Strength	Enter the strength of the drug in milligrams
12.	Quantity	Enter the quantity of the drug being prescribed
13.	Frequency of Dosing	Enter the dosing frequency
14.	Preferred Product	Indicate which preferred drug the patient has tried and failed in the past including the dosage per day. Preferred Drug List
15.	Reason	Circle the number on the form which corresponds to the type of failure experienced, and submit any required documentation.
16.	Clinical Explanation	Provide a written clinical explanation of the indicated failure to a preferred product including length of therapy, outcome and when commenced.
17.	Signature of Prescriber	The prescribing practitioner must sign the PA form; agent's signature is not acceptable
18.	Date (MMDDCCYY)	Enter the date the form was completed, signed, and submitted in MM/DD/CCYY format

STEP THERAPY CATEGORIES

ACNE AGENTS, TOPICAL

Preferred Step Therapy Agents	Non-Preferred Agents Requiring Step Therapy PA Request	
DIAGNOSIS CODE REQUIRED ON SELECT AGENTS - SEE NOTATION BELOW		
ACNE MEDICATION 5% & 10% GEL (OTC BENZOYL PEROXIDE)	ACANYA	EPIDUO FORTE (DX CODE REQ.)*
ACNE MEDICATION LOTION (OTC BENZOYL PEROXIDE)	ADAPALENE 0.1% CREAM (DX CODE REQ.)	ERY 2% PADS
ADAPALENE/BENZOYL PEROXIDE 0.1 - 2.5% (EPIDUO) (DX CODE REQ.	ADAPALENE 0.3% GEL, GEL PUMP (DX CODE REQ.)	ERYTHROMYCIN-BENZOYL GEL
ADAPALENE 0.1% GEL (OTC) (DX CODE REQ.)	ADAPALENE-BENZOYL PEROX 0.3 - 2.5% (DX CODE REQ.)	EVOCLIN
BENZOYL PEROXIDE 2.5%, 5%, 10% GEL (OTC)	AKLIEF (DX CODE REQ.)*	FABIOR (DX CODE REQ.)
BENZOYL PEROXIDE 5%, 10% WASH (OTC)	ALTRENO (DX CODE REQ.)	KLARON
CLINDAMYCIN PH 1% PLEGET	ARAZLO (DX CODE REQ.)	NEUAC
CLINDAMYCIN PH 1% GEL (not GENERIC CLINDAGEL)	ATRALIN (DX CODE REQ.)	ONEXTON
CLINDAMYCIN PH 1% LOTION, SOLUTION	AVAR, AVAR-E, AVAR LS	OVACE
CLINDAMYCIN / BENZOYL PEROXIDE 1.2 - 5% (generic DUAC)	BENZAMYCIN	RETIN-A MICRO (DX CODE REQ.)
ERYTHROMYCIN 2% GEL, SOLUTION	BPO FOAMING CLOTHS	ROSANIL*
RETIN-A CREAM (DX CODE REQ.)	CABTREO (DX CODE REQ.)	ROSULA
RETIN-A GEL (not MICRO) (DX CODE REQ.)	CLEOCIN T	SODIUM SULFACETAMIDE
	CLINDACIN FOAM, KIT	SODIUM SULFACETAMIDE-SULFUR
	CLINDAGEL	SSS CLEANSER, CREAM, FOAM
	CLINDAMYCIN GEL (generic CLINDAGEL), FOAM, LOTION	SUMADAN, SUMAXIN
	CLIND PH-BENZOYL PEROX 1 - 5%	TAZAROTENE (DX CODE REQ.)
	CLIND PH-BENZOYL PEROX 1.2 - 2.5%	TRETINOIN, TRETINOIN MICRO (DX CODE REQ.)
	CLIND PH-BENZOYL PEROX 1.2 - 3.75%	TWYNEO (DX CODE REQ.)*
	CLINDAMYCIN-TRETINOIN	WINLEVI
	DAPSONE	ZIANA
	DIFFERIN CREAM, GEL, LOTION, PUMP (DX CODE REQ.)*	ZMA CLEAR 9% - 4.5% SUSPENSION

CYTOKINE/CAM ANTAGONISTS

Preferred Step Therapy Agents	Non-Preferred Agents Requiring Step Therapy PA Request	
ADALIMUMAB-ADAZ*	ABRILADA	OLUMIANT
ADALIMUMAB-ADBM (not QUALLENT Brand)*	ACTEMRA	OMVOH
CYLTEZO SYRINGE*	ADALIMUMAB -AACF, -AATY, -FKJP, -RYVK	ORENCIA VIAL*
ENBREL DISP SYRINGE, KIT, PEN	ADALIMUMAB-ADBM* (QUALLENT Brand)	REMICADE
ENBREL MINI CARTRIDGE	AMJEVITA	RENFLEXIS
ENBREL VIAL	ARCALYST	RINVOQ
HADLIMA PUSHTOUCH, SYRINGE*	AVSOLA	SILIQ
HUMIRA KIT, PEN INJ KIT	BIMZELX	SIMLANDI*
INFLIXIMAB VIAL	CIBINQO	SIMPONI
ORENCIA CLICKJET, SYRINGE*	CIMZIA	SKYRIZI
OTEZLA STARTER PACK, TABLET	COSENTYX	SOTYKTU
TYENNE AUTOINJECT, SYRINGE, VIAL*	ENSPRYNG	SPEVIGO
XELJANZ IR TABLET (not XR or SOLUTION)	ENTYVIO	STELARA
	HULIO	TALTZ
	HYRIMOZ	TOFIDENCE*
	IDACIO	TREMFYA
	ILARIS	UPLIZNA
	ILUMYA	VELSIPITY
	INFLECTRA	XELJANZ SOLUTION, XELJANZ XR
	KEVZARA	YUFLYMA
	KINERET	YUSIMRY
	LITFULO*	ZYMFENTRA*

ANTIMIGRAINE AGENTS, TRIPTAN

Preferred Step Therapy Agents	Non-Preferred Agents Requiring Step Therapy PA Request	
RELPAX TABLET	ALMOTRIPTAN	SUMATRIPTAN AUTOINJECT, CARTRIDGE
RIZATRIPTAN ODT	ELETRIPTAN	SUMATRIPTAN-NAPROXEN
RIZATRIPTAN TABLET	FROVA & FROVATRIPTAN	TOSYMRA
SUMATRIPTAN NASAL SPRAY	IMITREX	ZEMBRACE
SUMATRIPTAN TABLET	MAXALT, MAXALT MLT	ZOLMITRIPTAN, ZOLMITRIPTAN ODT
SUMATRIPTAN VIAL (not AUTOINJECT)	NARATRIPTAN	ZOMIG

LIPOTROPICS, STATINS

Preferred Step Therapy Agents	Non-Preferred Agents Requiring Step Therapy PA Request	
ATORVASTATIN TABLET	ALTOPREV	FLUVASTATIN, FLUVASTATIN ER
LOVASTATIN TABLET	AMLODIPINE-ATORVASTATIN	LESCOL XL
PRAVASTATIN TABLET	ATORVALIQ	LIPITOR
ROSUVASTATIN TABLET	CADUET	LIVALO
SIMVASTATIN TABLET	CRESTOR	PITAVASTATIN
	EZALLOR SPRINKLE	VYTORIN
	EZETIMZBE-SIMVASTATIN	ZOCOR
	FLOLIPID*	ZYPITAMAG

PROTON PUMP INHIBITORS

Preferred Step Therapy Agents	Non-Preferred Agents Requiring Step Therapy PA Request	
ESOMEPRAZOLE 20MG CAPSULE (OTC & RX)	ACIPHEX	OMEPRAZOLE (OTC VERSIONS)
ESOMEPRAZOLE 40MG CAPSULE	DEXILANT	OMEPRAZOLE-SODIUM BICARBONATE
NEXIUM PACKET SUSPENSION (not CAPSULE)	DEXLANSOPRAZOLE	PANTOPRAZOLE 40 MG SUSPENSION PKT
OMEPRAZOLE 10MG, 20MG, 40MG CAPSULE (Rx ONLY)	ESOMEPRAZOLE PACKET	PREVACID
PANTOPRAZOLE TABLET	ESOMEPRAZOLE (OTC TABLET)	PRIOLOSEC
PROTONIX SUSPENSION	KONVOMEP	PROTONIX TABLET
	LANSOPRAZOLE	RABEPRAZOLE
	NEXIUM CAPSULE	ZEGERID

(DX Code Req) notation for agents that require ICD-10 code
Preferred Brand Name medications are listed in **BOLD**
*Updated 1/1/2025