**STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES**
**TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 OR (860) 269-2035**

# 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).

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.

This form (and attachments) contains protected health information (PHI) for DXC Technology and is covered by the Electronic Communications Privacy Act, 18 U.S.C. § 2510-2521 and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, which is intended only for the use of prior authorization. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited. Any unintended recipient should contact DXC Technology by telephone at (860) 255-3900 or by e-mail immediately and destroy the original message.

## (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 |

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# STEP THERAPY CATEGORIES

## ACNE AGENTS, TOPICAL

| Preferred Step Therapy Agents | Non-Preferred Agents Requiring Step Therapy PA Request | |
|---|---|---|
| AZELEX 20% CREAM | ACANYA | ERYGEL |
| BENZOYL PEROXIDE CREAM, GEL, WASH (not FOAM) (TOPICAL)* | ACZONE | ERYTHROMYCIN 2% GEL, PLEDGETS |
| BENZOYL PEROXIDE 6% CLENSER (OTC) (TOPICAL)* | ADAPALENE | ERYTHROMYCIN-BENZOYL |
| BPO GEL (OTC) (TOPICAL)* | ADAPALENE-BENZOYL PEROXIDE | EVOCLIN |
| CLINDAMYCIN PHOSPHATE 1% PLEGET | AKLIEF | FABIOR |
| CLINDAMYCIN PHOSPHATE 1% SOLUTION | ALTRENO | KLARON |
| CLIND PH-BENZOYL PEROX 1.2-5% | ATRALIN | NEUAC |
| **DIFFERIN 0.1% CREAM** | AVAR | ONEXTON |
| DIFFERIN 0.1% LOTION | AVITA | OVACE |
| **DIFFERIN 0.3% GEL PUMP** | BENZACLIN | PLIXDA |
| **EPIDUO 0.1-2.5% GEL PUMP** | BENZAMYCIN | RETIN-A MICRO |
| ERYTHROMYCIN 2% SOLUTION | BENZOYL PEROXIDE | ROSANIL |
| **RETIN-A CREAM** | BPO | ROSULA |
| **RETIN-A GEL** | CLEOCIN T | SODIUM SULFACETAMIDE |
| | CLINDACIN KIT | SODIUM SULFACETAMIDE-SULFUR |
| | CLINDAGEL | SSS CREAM, FOAM |
| | CLINDAMYCIN PHOS GEL, FOAM, LOTION | SUMADAN |
| | CLINDAMYCIN-BENZOYL PEROXIDE 1-5% GEL | SUMAXIN |
| | CLINDAMYCIN-TRETINOIN | TAZAROTENE |
| | DAPSONE | TAZORAC |
| | DUAC | TRETINOIN |
| | EPIDUO FORTE | ZIANA |
| | ERY 2% PADS | |

## CYTOKINE/CAM ANTAGONISTS

| Preferred Step Therapy Agents | Non-Preferred Agents Requiring Step Therapy PA Request | |
|---|---|---|
| COSENTYX | ACTEMRA | OTEZLA |
| ENBREL | ARCALYST | REMICADE |
| HUMIRA | CIMZIA | RENFLEXIS |
| | ENTYVIO | SILIQ |
| | ILARIS | SIMPONI |
| | ILUMYA | SKYRIZI |
| | INFLECTRA | STELARA |
| | KEVZARA | TALTZ |
| | KINERET | TREMFYA |
| | OLUMIANT | XELJANZ |
| | ORENCIA | |

## ANTIMIGRAINE AGENTS

| Preferred Step Therapy Agents | Non-Preferred Agents Requiring Step Therapy PA Request | |
|---|---|---|
| **RELPAX TABLET** | ALMOTRIPTAN | ONZETRA |
| RIZATRIPTAN ODT | AMERGE | SUMATRIPTAN CARTRIDGE |
| RIZATRIPTAN TABLET | ELETRIPTAN | SUMATRIPTAN SYRINGE |
| SUMATRIPTAN NASAL SPRAY | FROVA | SUMATRIPTAN-NAPROXEN |
| SUMATRIPTAN TABLET | FROVATRIPTAN | SUMAVEL |
| SUMATRIPTAN VIAL | IMITREX | TREXIMET |
| | MAXALT | ZEMBRACE |
| | MIGRANOW | ZOLMITRIPTAN |
| | NARATRIPTAN | ZOMIG |

## LIPOTROPICS, STATINS

| Preferred Step Therapy Agents | Non-Preferred Agents Requiring Step Therapy PA Request | |
|---|---|---|
| ATORVASTATIN | ALTOPREV | LIVALO |
| **CRESTOR** | AMLODIPINE-ATORVAST | PRAVACHOL |
| LOVASTATIN | CADUET | ROSUVASTATIN |
| PRAVASTATIN | EZETIMIBE-SIMVASTATIN | VYTORIN |
| SIMVASTATIN | FLUVASTATIN | ZOCOR |
| | LESCOL | ZYPITAMAG |
| | LIPITOR | |

## PROTON PUMP INHIBITORS

| Preferred Step Therapy Agents | Non-Preferred Agents Requiring Step Therapy PA Request | |
|---|---|---|
| ESOMEPRAZOLE CAPSULES 20MG & 40MG (Rx ONLY) | ACIPHEX | OMEPRAZOLE-BICARB |
| NEXIUM SUSPENSION | DEXILANT | PREVACID |
| OMEPRAZOLE CAPSULES (Rx ONLY) | ESOMEPRAZOLE (OTC VERSIONS) | PRIOLOSEC |
| PANTOPRAZOLE | LANSOPRAZOLE | PROTONIX TABLET |
| PROTONIX SUSPENSION | NEXIUM CAPSULE | RABEPRAZOLE |
| | OMEPRAZOLE (OTC VERSIONS) | ZEGERID |

Updated 10/23/2019