# Florida Step Therapy Exemption Request

**For plans subject to FL SB 1550.**

The member's prescription benefit plan may request additional information or clarification, if needed, to evaluate requests.

**Patient's Name:** _____ **Date**: _____
**Patient's ID:** _____ **Patient's Date of Birth:** _____
**Physician's Name:** _____
**Specialty:** _____ **NPI#:** _____
**Physician Office Telephone:** _____ **Physician Office Fax:** _____

What drug is being prescribed? _____
What is the patient's diagnosis? _____
What is the ICD-10 code? _____

1. Has the patient received a step therapy approval for the requested drug by a prior plan? ☐ Yes ☐ No
   *(Note: Approval can be considered for a different strength of the previously approved drug. Approval can be considered for a generic drug if the previous approval was for the brand drug. However, approval will not be considered for a brand drug if the previous approval was for the generic drug)*
   *If yes, go to 2. If no, go to 3*
2. Has the requested drug been dispensed at a pharmacy and approved for coverage by a prior plan in the immediate past 90 days? ☐ Yes ☐ No
   *(Note: If yes, then documentation supporting a paid claim in the immediate past 90 days is required. Verbal documentation is not permitted.) If yes, then no further questions. If no, go to 3*
3. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? ☐ Yes ☐ No
   *If yes, go to 4. If no, then no further questions.*
4. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature? ☐ Yes ☐ No
   *If yes, go to 5. If no, then no further questions*
5. Has the patient experienced an inadequate treatment response to a preferred drug? ☐ Yes ☐ No
   *If yes, then no further questions. If no, go to 6.*
6. Has the patient experienced an intolerance to a preferred drug? ☐ Yes ☐ No
   *If yes, then no further questions. If no, go to 7*
7. Does the patient have a contraindication that would prohibit a trial of a preferred drug? ☐ Yes ☐ No
   *No further questions*

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark, the benefit plan sponsor, or (if applicable) any state or federal regulatory agency.***

**X**_____

**Prescriber or Authorized Signature** **Date (mm/dd/yyyy)**

**Send completed form to: CVS Caremark Prior Authorization Fax: 1-888-836-0730**



**CVS Caremark Prior Authorization ● 1300 E. Campbell Rd. ● Richardson, TX 75081**
**Fax: 1-888-836-0730 ● www.caremark.com**



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