



ADVANTAGE Step Therapy Information for New / Enrolling ADVANTAGE Members

If you are a new member or just enrolling with ADVANTAGE and are currently receiving prescription drug therapy, please review page 3 of the 2009 ADVANTAGE Formulary regarding the ADVANTAGE Step Therapy Pharmacy Program.

If you currently have been receiving one of the following medications listed on page 3 of the formulary under your doctor's prescription within the last 6 months, you need to have your physician complete the reverse side of this form and fax it to the number listed BEFORE you go to the pharmacy.

As a new member starting with ADVANTAGE, you are eligible to continue on any of these medications if you have been taking them within the most recent 6 months. However, your physician needs to complete the form on the reverse side of this sheet and fax it to the number listed BEFORE you go to the pharmacy in order for your prescription to be covered.

Please take this sheet to your prescriber and ask that he or she complete the reverse side and fax it as necessary. If you have questions regarding Step Therapy, you may visit our website at www.advantageplan.com or contact member services at 800-553-8933 or 317-573-6228.

Sincerely,
ADVANTAGE Health Solutions, Inc.sm

PLAN EXCEPTION REQUEST FORM

****Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA, as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment, and healthcare operations (TPO). HIPAA does not restrict the communication of PHI with providers for TPO related purposes.**

Date of Request _____

Case # _____

Member Name	DOB
Member Identification Number	TPC
Physician Name	DEA# / Specialty
Physician Phone #	Physician Fax #

Medication / Dose Requested: _____

We have received your request for prior authorization for the patient and medication listed above. In order to complete our review and make an appropriate determination, the following information will be necessary:

NOTE Under ADVANTAGE policy, patient must have been prescribed and actively using the medication within the most recent 180 days, and physician provided samples will not qualify. Requests outside of 180 days or based on physician provided samples will be denied.

Reason for Request:

Diagnosis: _____ ICD-9 Code: _____

Clinical rationale for request: **CONTINUATION OF EXISTING MEDICATION SUBJECT TO STEP THERAPY FOR NEWLY ENROLLED PLAN MEMBERS ONLY**

Previous medications treatment history (provide reason for treatment failure): _____

For mandatory generic or formulary exception, please specify dates and reason for treatment failure of the generic product, if applicable:

Other relevant patient information: _____

Physician Signature: _____ **Date:** _____

**Physician signature field must be completed. Requests will not be reviewed in the event that this field is incomplete.

**Please call 800.361.4542 for assistance in filling out this form. (Dr. office only). Most requests are processed within one business day of receiving complete information. Some requests may, however, require more time to review.

COMPLETED FORMS MUST BE FAXED TO ENVISION R_xOPTIONS AT 330.405.8081