



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 the formulary under your doctor's prescription within the last 180 days, 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 step therapy medications if you have been taking them within the most recent 180 days. 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. If you do not complete this form before you go to the pharmacy, you may be required to pay the entire cost of your medication until appropriate documentation has been received and reviewed.

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, please refer to your prescription drug formulary, 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:

Reason for Request:

New Member Step Therapy

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 877-684-0021 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 RxEPTIONS AT 330-405-8081.