Connecticut Department of Social Services
Medical Assistance Program
www.ctdssmap.com

Provider Bulletin 2014-64
September 2014

TO: **Pharmacy Providers, Physicians, Nurse Practitioners, Dental Providers, Physician Assistants, Optometrists, Long Term Care Providers, Clinics, and Hospitals**

RE: **New Prior Authorization Form for Step Therapy Additional Classes**

As previously announced in Provider Bulletin 2013-26, the Department of Social Services (DSS) is expanding Step Therapy Prior Authorization (PA) criteria to include the following drug classes:

- Statins
- Anti-Migraine Agents

Effective October 1, 2014, the newly developed Step Therapy PA Request Form will replace the currently utilized Step Therapy Proton Pump Inhibitor (PPI) PA Request Form and must be used to request a PA for any non-preferred Step Therapy drug. The Pharmacy Web PA feature on the www.ctdssmap.com secure Web portal will also allow providers to request PA for drugs subject to Step Therapy.

The Step Therapy PA Request Form requires prescribers to explain in detail why the client cannot be treated with one of the currently preferred agents. The prescriber must indicate which preferred product has been utilized in the past, select a reason for the failure, and supply a specific written clinical explanation for the failure. Documentation of the failure must be maintained in the patient's chart. The allowable reasons that may be indicated on the form are:

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

Please note: the Department will honor previous authorizations for drugs newly subject to the Step Therapy PA criteria approved prior to October 1, 2014 for dates of service on or after October 1, 2014 up to a period of one year.

The new Step Therapy PA form is attached below and will be available on the www.ctdssmap.com Web site before October 1, 2014. From the Home page, go to Information → Publications → Forms → Authorization/Certification Forms → Step Therapy PA Form; or to Pharmacy Information → Pharmacy Program Publications → Step Therapy PA Form.

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
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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

[This and other pharmacy PA forms are available at www.ctdssmap.com]

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 non-PDL 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 HP 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 HP by telephone at (860) 255-3900 or by e-mail immediately and destroy the original message.

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
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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