Nevada Cancer Step Therapy Exception/Prior Authorization Request Form

Fax this form to: 1-877-269-9916
Or submit your request online at:
https://www.availity.com/
Visit www.aetna.com/formulary/ to access our Pharmacy Clinical Policy Bulletins

For FASTEST service, call 1-855-240-0535, Monday - Friday, 8 a.m. to 6 p.m. Central Time

Patient Information			**Prescriber Information**		
Patient Name:		DOB:	Prescriber Name:		
Patient ID Number:			Address:		
Address:			City:	State:	Zip:
City:	State:	Zip:	Office Phone Number:	Office Fax Number:	
Home Phone:		Gender: ☐ Male ☐ Female	Contact Person at Doctor's Office:		

Diagnosis and Medical Information			
Medication and Strength:	Directions for use (Frequency):	Expected Length of Therapy:	
Qty:	Day Supply:	Has the patient been receiving the requested drug within the last 120 days? ☐ Yes ☐ No	
Diagnosis (ICD) Code(s):		Has the requested drug been dispensed at a pharmacy and approved for coverage previously by a prior plan? ☐ Yes ☐ No	
Diagnosis:		How long has the patient been on the requested medication?	

PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION
Solely providing demographic information with a diagnosis may not constitute a sufficient request for coverage.
Specific drugs/classes are listed on page 2. For any drugs/classes not listed, please attach relevant clinical documentation.

☐ **Expedited/Urgent Review Requested:** *By checking this box, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.*

Please list all medications the patient has tried specific to the diagnosis and specify below:
Medication name, reason for failure, including trial year:
Drug(s) contraindicated:
Adverse event (e.g., toxicity, allergy) for each drug:
Is the request for a patient with a highly sensitive condition (e.g., psychiatric condition, epilepsy, organ transplant) who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change? If yes, specify anticipated significant adverse event:
Does the patient have a chronic condition confirmed by diagnostic testing? ***If yes, please provide diagnostic test and date***:
Does the patient require a specific dosage form (e.g., suspension, solution, injection)? ***If yes, please provide dosage form***:
Does the patient have a clinical condition for which other formulary alternatives are not recommended or are contraindicated due to comorbidities or drug interactions based on published clinical literature? If so, please provide documentation including medication names and clinical reasons.

PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS. PLEASE FAX COMPLETED FORM TO 1-888-836-0730.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.

Prescriber Signature: _____ **Date**: _____

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Application for exemption from Step Therapy Protocol for patients diagnosed with stage 3 or 4 cancer will be reviewed by at least one physician, registered nurse, or pharmacist. (This Step Therapy Exception applies only to plans subject to Nevada State laws.)

PLEASE COMPLETE CRITERIA BELOW BY CIRCLING THE APPROPRIATE ANSWER OR SUPPLY RESPONSE.

CRITERIA ONCOLOGY STATE OF NEVADA PA REG		**Ref # 4881-A**	
1	Has the patient been diagnosed with stage 3 or 4 cancer?	Yes ☐	No ☐
2	Has the patient tried the alternate drug or other drugs included in the same pharmacological drug class or having the same mechanism of action of the requested drug and it has not been effective at treating the cancer or symptoms of the patient when prescribed in accordance with clinical indications, clinical guidelines or other peer-reviewed evidence?	Yes ☐	No ☐
3	Would delay of effective treatment have severe or irreversible consequences for the patient and the alternate drug is not reasonably expected to be effective based on the physical or mental characteristics of the patient and the known characteristics of the treatment?	Yes ☐	No ☐
4	Is the alternate drug contraindicated for the patient or has caused or is likely, based on peer-reviewed clinical evidence, to cause an adverse reaction or other physical harm to the patient?	Yes ☐	No ☐
5	Has the alternate drug prevented or is likely to prevent the patient from performing the responsibilities of their occupation or engaging in activities of daily living, as defined under federal regulations?	Yes ☐	No ☐
6	Is the patient's condition stable while being treated with the requested drug and the patient has previously received approval for coverage of the drug?	Yes ☐	No ☐

RATIONALE

These criteria were developed to meet state-specific regulatory requirements to determine drug coverage through a utilization management process that aligns with state mandated legislation for patients who have been diagnosed with stage 3 or 4 cancer or the attending practitioner of the patient to apply for an exemption from step therapy that would otherwise be required for a prescription drug to treat the cancer or any symptom thereof of the patient.

REFERENCES

1. State of Nevada Senate Bill No. 290. June 2021.