# State of Nevada Step Therapy Protocol Exception Process

Members covered by a Nevada fully insured plan, or a Nevada self-insured non-ERISA plan, may require treatment with a prescription drug is subject to certain utilization management (UM) criteria or rules to be reviewed prior to coverage. These rules may include Step Therapy Requirements.

If medication on the formulary requires Step Therapy, a health care provider may request an exception to the Step Therapy protocol by completing and submitting the applicable prior authorization (PA) form. The provider may contact the CVS Caremark® Prior Authorization Department for the appropriate PA form or the form can be found at this link:

For Oncology medications:

Nevada Cancer Step Therapy Exception/Prior Authorization Request Form

For all other medications:

Medical Exception / Prior Authorization / Precertification Request for Prescription Medications

As part of the authorization process, CVS Caremark will review the information submitted by the medical provider and determine if a request meets the requirements for exception based on the information below.

* Note that medical necessity requirements may still apply.

**Consideration for Receiving a Step Therapy Protocol Exception**

The requested medication may be covered when any of the below are met and documentation has been provided**:**

- Contraindication to or likely adverse reaction or physical or mental harm to the patient from the medication that is required to be used or tried first (alternate drug).
- The alternate drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen.
- The patient has tried the alternate drug while under the current or previous health benefit plan, or another prescription drug in the same pharmacological class or with the same mechanism of action, and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- The alternate drug is not in the best interest of the patient based on medical necessity.
- The patient is stable on the requested drug selected by the patient's healthcare provider for the medical condition under consideration while on the current or previous health benefit plan.

For insured Aetna Commercial plans, please use the link below to access the clinical review criteria for prescription drugs: https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/pharmacy-clinicalpolicy-bulletins.html

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