HEALTH PLAN SELECT
Athens Area Health Plan Select Inc.
Affiliated with Athens Regional Medical Center

Medical Exception for Step Therapy Drugs

Please complete form and fax to: (706) 549-8004

Patient Name:_____ Date:_____

Patient Insurance ID:_____ Patient's Date of Birth:_____

Ordering Physician:_____ Fax Number: ( ) _____

Physician or Nurse Signature(required):_____

☐ **Approved** _____**(from/to)** _____ ☐ **Denied**

HPS Use Only

Cox II Inhibitor and Nsaids:

What drug is being requested? (*please circle*) Celebrex Mobic

What dosage is being requested? _____mg (*please circle*) QD BID

What is the patient's diagnosis? (*circle all that apply*) Osteoarthritis Rheumatoid Arthritis Acute Pain

Primary Dysmenorrhea Familial Adenomatous Polyposis Other:_____

List previous therapy, with dates (**must of tried and failed 2 other nsaids**): _____

Is the patient age 18 year or older? Yes No

Does the patient have a history of peptic ulcer disease or NSAID-related ulcer/GI bleeding? Yes No

Is the patient currently using anticoagulants, antiplatelets, or corticosteroids? Yes No

Antiemetic Agents (Anzemet, Kytril, Marinol, Zofran)

What drug is being requested? (please circle) Anzemet Kytril Marinol Zofran

What dosage is being requested? _____mg

Is the patient receiving emetogenic chemotherapy or radio-therapy? Yes No

Does the patient require treatment to prevent postoperative nausea and/or vomiting? Yes No

Has the patient **tried and failed** at least two (2) of the following antiemetic therapies or are two (2) or more of these drug contraindicated?: prochlorperazine, thiethylperazine, promethazine, metoclopramide?

Is the patient allergic to all or part of the formulation (e.g., dyes, talc, wheat products) for three (3) or more of the following drugs: prochlorperazine, thiethylperazine, promethazine, metoclopramide?

For Marinol

Does the patient have the diagnosis of anorexia associated with AIDS? Yes No

Respiratory Drugs – Leukotrien Modifiers (Singulair & Accolate)

Which drug is being prescribed? (please circle) Singulair Accolate

What dosage is being requested? _____mg

Does the patient have a diagnosis of asthma? Yes No

Has the patient tried a 30-day supply each of two (2) non-sedating antihistamines (prescription or non-prescription)? Yes No

Has the patient tried a 30-day supply **each** of two (2) non-sedating antihistamines (e.g., Astelin) or nasal corticosteroid (e.g., Nasacort, Nasonex, Flonase) within the previous 180 days? Yes No

Acne Medications –Retin A*, Avita*, Altinac, Differin and Tazorac

Which drug is being prescribed? (please circle) Retin A* Avita* Altinac Differin Tazorac

Does the patient have a diagnosis of Acne Vulgaris (also known as cystic or pustular)? Yes No

Is the patient's acne considered mild to moderate inflammatory acne? Yes No What dosage? _____

If yes, has the patient tried two (2) or more of the following drugs for a 14-day supply each? Clindamycin, erythromycin, sulfacetamide/sulfur, sufacetamide, tetracycline, benzoyl peroxide, minocycline, or doxycycline. (please circle)

*** Drug is excluded for patients > 27 years of age without exception**