Step Therapy Request Form

Branded Diabetics Step Therapy

Actos, Actosplus Met, Byetta, Januvia, Janumet, Onglyza, Starlix, Symlin
(Avandamet, Avandaryl, Avandia, Duetact, Fortamet, Glycron, Glyset, Prandin- see formulary for preferred products)

Patient Information	Prescriber Information
Member Name:	Prescriber Name:
Bravo ID #	Prescriber Specialty:
DOB:	Prescriber Address:
Address:	
	Office Phone#:
	Office Fax #:
	Contact Person:

Diagnosis and Medication Requested

Medication Requested (dosage, frequency): Qty:

Prescribing Diagnosis: ICD9 Code Date Therapy Initiated:

Rationale for Step Therapy
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

1. **Has the member experienced an inadequate response or intolerance with either metformin or sulfonylurea?**
2. **Has the member experienced an inadequate response or intolerance with another oral hypoglycemic agent?**

Please provide rationale supporting request for Step Therapy.

- Please provide clinical documentation supporting :
  - Name of alternate therapy, dates and duration of alternate therapy and outcome of each.

REQUIRED EXPLANATION:

Failure to provide clinical documentation supporting rationale may result in this request being denied

Request for Expedited Review

☐ **REQUEST FOR EXPEDITED REVIEW [24 HOURS]**
BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Prescriber's Signature: _____ **Date:** _____

Fax back to: 866-464-0709 **For info call: 877-813-5595**

For additional Prior Authorization forms, http://www.bravohealth.com/Providers/PrescriptionDrug/Forms.aspx