Hometown Health

# Oncology Step Therapy Exemption Form

Attn: Prior Authorization Department

10315 Professional Circle Reno, NV 89521
Phone: 1-844-373-0970
Fax: 1-866-521-9916

## Instructions:

This form is to be used by participating physicians and providers to request a step therapy exemption for patients who have been diagnosed with stage three or four cancer (Chapter 689A of NRS, Section 1).

**Please complete this form and attach any pertinent documentation such as chart notes and labs regarding medication requested and fax to Hometown Health at (866)-521-9916 or call (844)-373-0970 if you have any questions regarding this exemption process.**

*****Requests submitted without documentation may be delayed or potentially denied*****

## Review Criteria:

The following criteria are used in reviewing medication requests:

1. The use of Formulary Drug Products is contraindicated in the patient.
2. The patient has failed an appropriate trial of Formulary or related agents.
3. The choices available in the Formulary are not suited for the patient care need and the drug selected is required for patient safety.
4. The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care.

☐ REQUEST FOR EXPEDITED (URGENT) REVIEW: BY CHECKING THIS BOX, I CERTIFY THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Medication Request Information (please complete each section of this form prior to transmittal): *Denotes Required Fields

| PATIENT INFORMATION | | PHYSICIAN INFORMATION | |
|---|---|---|---|
| *Name: | | *Name: | |
| *ID#: | | *Specialty: | |
| *Date of Birth: | | ID# / DEA#: | |
| *Health Plan: | | *Phone: ( ) - | *Fax: ( ) - |
| *Diagnosis (ICD-10 Code, if known or description): | | | |
| **REQUESTED DRUG INFORMATION** | | **PHARMACY INFORMATION** | |
| *Requested Drug: | | Name: | |
| Dose: | Strength: | Phone: ( ) - | Fax: ( ) - |
| Quantity: (per month) | Dosage Form: (Oral, Injection, etc.) | Length of Treatment: (Please be specific.) | |
| Reason for Medication Request (Diagnosis, ICD 10 code and other pertinent information): | | | |
| Other Medications Tried and/or Failed (Please be specific, give detail.): | | | |
| Other Pertinent History (Relative or pertaining to this request.): | | | |

Revised: 11/2021