



PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 1/18/18
LAST REVIEW DATE: 8/13/18
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

STEP THERAPY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as “Description” defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as “Criteria” defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

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This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

STEP THERAPY (cont.)

Description:

Prescription Drug Benefit plans apply various management strategies that put limitations on certain medications. These may include, but are not limited to, precertification (or prior authorization), quantity limits and step therapy.

BCBSAZ determines which medications are subject to limitations based upon medication product labeling, nationally recognized compendia or guidelines, and established clinical trials that have been published in peer reviewed professional medical journals. Medication limitations are subject to change at any time without prior notice.

Step Therapy is the practice of beginning a drug for a medical condition with a preferred drug before progressing to another therapy. It requires trying a Step Therapy Drug A before getting Step Therapy Drug B. Step therapy guidelines are developed and reviewed by a panel of practicing physicians and pharmacists.

Step therapy is an automated process. When a prescription for a step therapy medication (drug "B") is presented to a pharmacy, an automated check of the member's prescription history occurs. If the system finds that the member has received a drug "A", the prescription for the step therapy medication drug "B" will automatically process.

If the system does not find the drug "A" in the member's prescription history, a precertification will be necessary. Precertification allows providers to submit medical record documentation of failure, intolerance, or contraindications that may exist for drug "A" which would suggest approval to bypass use of the preferred product. BCBSAZ will review the information presented and if approved, an authorization for drug "B" can be entered into the member's pharmacy record.

BCBSAZ maintains a list of medications that require step therapy and is available on www.azblue.com/pharmacy by selecting the appropriate plan option, or click [here](#).

Criteria:

➤ **Criteria for initial therapy:** Step Therapy Medication is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:

1. Individual age is appropriate for the requested Step Therapy Medication
2. A confirmed diagnosis that is treated by a Step Therapy Medication
3. Individual has failure, contraindication or intolerance to drugs listed in **Step Edit Criteria** referenced in **Step Therapy Drug List** (click [here](#))
4. There are **NO** contraindications



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STEP THERAPY (cont.)

- **Continuation of coverage (renewal request)**: Step Therapy Medication is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:
1. Individual's condition responded while on therapy
 2. Individual has been adherent with the medication
 3. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
 4. There are no significant interacting drugs
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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
 Call 866-325-1794 to check the status of a request.
 All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
 Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information			
Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information			
Medication Name:	Strength:	Dosage Form:	
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

Check if requesting **brand** only Check if requesting **generic**

Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review	
<input type="checkbox"/> Standard <input type="checkbox"/> Urgent. Sign here: _____	<input type="checkbox"/> Exigent (requires prescriber to include a written statement)

Clinical Information	
1. What is the diagnosis? Please specify below. ICD-10 Code: _____ Diagnosis Description: _____	
2. <input type="checkbox"/> Yes <input type="checkbox"/> No Was this medication started on a recent hospital discharge or emergency room visit?	
3. <input type="checkbox"/> Yes <input type="checkbox"/> No There is absence of ALL contraindications.	

4. What medication(s) has the individual tried and failed for this diagnosis? Please specify below.
 Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. Are there any supporting labs or test results? Please specify below.

Date	Test	Value

Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature:	Date:
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Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.