mercy care
advantage
HMO SNP

# PART B DRUG PRIOR AUTHORIZATION REQUEST
# OR
# PART B DRUG STEP THERAPY EXCEPTION REQUEST

This form may be used to request prior authorization for a Part B drug or to request a Step Therapy Exception for a Part B drug for Mercy Care Advantage members.

To view the Part B drug Step Therapy list, visit our website at www.MercyCareAZ.org.

Please fax your completed form to: **800-217-9345.**
If your request is urgent, please call us at: **602-623-3000 or 800-624-3879**.

Requests for Part B drugs will be reviewed within 24 hours (expedited request) or 72 hours (standard request) of receipt with supporting information. Please note in the form if this is an expedited request.

Requests for a Part B Step Therapy Exception **must** include a physician supporting statement reflecting trial and failure of the preferred drug(s), or medical reason why the member cannot take the preferred drug(s), or medical reason why the preferred drug(s) would not be as effective as the non-preferred drug for the member.

**Member Information**

| | |
|---|---|
| Member Name | Date of Birth |
| Phone | Member ID # |
| Address | |

**Ordering Physician Information**

| | |
|---|---|
| Name | |
| Address | |
| TIN/NPI #: | Office Contact Person: |
| Office Phone | Fax |

**Servicing Provider Information** ☐ **Check box here if the same as ordering provider**

| | |
|---|---|
| Name | |
| Address | |
| TIN/NPI #: | Office Contact Person: |

| Office Phone | Fax |
|---|---|

**Part B drug requested (name, CPT code, dose/units):**

☐ **REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72-hour standard review timeframe may seriously jeopardize the life or health of the member.

**Supporting Information for Prior Authorization or Step Therapy Exception Request**

☐ I request prior authorization for the Part B drug listed above.

☐ I request an exception to the step therapy requirement that the preferred Part B drug(s) must be tried before a non-preferred Part B drug can be approved.

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**NOTE: If a Part B drug step therapy exception is requested, the ordering physician MUST provide a supporting statement reflecting the trial and failure of the preferred drug(s), or medical reason why the member cannot take preferred drug(s), or medical reason why the preferred drug(s) would not be as effective as the non-preferred drug for the member.**

Please include additional information we should consider *(attach any supporting documents)*:

| **Diagnosis and Medical Information** | |
|---|---|
| **DIAGNOSIS – Please list all diagnoses to be treated with the requested drug and corresponding ICD-10 codes.** | **ICD-10 Code(s)** |

**DRUG HISTORY: (**for treatment of the condition(s) requiring the requested drug)

| DRUGS TRIED | DATES of Drug Trials | RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please provide rationale for this request:

| **Physician Signature** | **Date** |
|---|---|
| | |