



STEP THERAPY DRUG REQUEST FORM

(Incomplete form may delay processing)

| Prescriber Information | | Patient Information | |
|------------------------|----------------------|-------------------------|------|
| Prescriber Name: | Provider ID/Tax ID : | Patient Name: | |
| Office Contact Person: | | BCBSNC ID # : | |
| Prescriber Phone # : | Prescriber Fax # : | Home Phone # : | |
| Address: | | Sex (circle): M F | DOB: |
| City: | State: | Zip: | |

FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

The **nonpreferred** proton pump inhibitors (PPIs) and intranasal steroids listed below require physician certification that:

- Member has previously used a preferred medication in its class,
AND
- Such drug has been ineffective or detrimental to the member's health and is likely to be detrimental to the member's health or ineffective in treating this condition again.

Proton Pump Inhibitors (PPIs)

Coverage for PPIs will be limited to **preferred** agents **omeprazole, lansoprazole capsule, omeprazole / sodium bicarbonate, pantoprazole** and **Nexium[®]**, unless certification is provided by the physician stating that the patient meets the specific criteria listed above.

Preferred Drug previously taken by patient:

- Omeprazole (Prilosec[®])
- Lansoprazole capsule (Prevacid[®])
- Omeprazole / sodium bicarbonate
- Pantoprazole (Protonix[®])
- Nexium[®]

Nonpreferred Drug Requested:

- Prevacid[®] SoluTab
- Zegerid[®] packet
- Protonix[®] 40 mg suspension
- Aciphex[®]
- Dexilant[™]/Kapidex[™]

Intranasal Steroids

Coverage for intranasal steroids will be limited to **preferred** agents **fluticasone propionate, flunisolide**, and **Nasonex[®]**, unless certification is provided by the physician stating that the patient meets the specific criteria listed above.

Preferred Drug previously taken by patient:

- Fluticasone propionate (Flonase[®])
- Flunisolide (Nasarel[®])
- Nasonex[®]

Nonpreferred Drug Requested:

- Beconase AQ[®]
- Nasacort AQ[®]
- Omnaris[®]
- Rhinocort Aqua[®]
- Veramyst[®]

I certify that, to the best of my knowledge, the above-referenced patient has previously used a **preferred medication** in its class and such drug has been detrimental to the patient's health or has been ineffective in treating the patient's condition and, in my opinion, is likely to be detrimental to the patient's health or ineffective in treating the condition again.

Prescriber's Signature: _____ Date: _____

Please Return Completed Form to: Fax number: 1-888-446-8535
 Address: BCBSNC
 Attention: Exceptions-Healthcare Services
 P.O. Box 17509
 Winston-Salem, NC 27116-7509
 Provider Telephone: 1-888-296-9790

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