Serious Mental Illness Step Therapy Exception Form

Plan/Medical Group Name:_____ **Plan/Medical Group Fax#: (_____)** _____

Plan/Medical Group Phone #: (_____)

Instructions: Please fill out all applicable sections completely and legibly. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information			
First Name:	MI:	Last Name:	Date of Birth:
City:	State:	Zip Code:	Phone Number:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number (if applicable):	

Insurance Information	
Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information			
First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
NPI Number (individual):		Phone Number:	
DEA Number (if applicable):		Office Contact Person:	
Email Address:			

Medication:
Diagnosis:
Medication:

Attestation

☐ I attest the information provided is true and accurate to the best of my knowledge.

☐ I attest that any of the following criteria specified in subsections (4)(a)(I) –(IV) of § 10-16-145, C.R.S. have been met to exempt a step-therapy requirement for the prescription drug:

- (I) The provider attests that the required prescription drug is contraindicated or will likely cause an adverse reaction or harm to the covered person;
- (II) The required prescription drug is ineffective based on the known clinical characteristics of the covered person and the known characteristics of the prescription drug regimen;
- (III) The covered person has tried, while under the covered person's current or previous health benefit plan, the required prescription drug or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the use of the prescription drug by the covered person was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
- (IV) The covered person, while on the covered person's current or previous health benefit plan, is stable on a prescription drug selected by the prescribing provider for the medical condition under consideration after undergoing step therapy or after having sought and received a step-therapy exception.

Prescriber Signature or Electronic I.D. Verification:_____ Date: _____