Non-Formulary or Step Therapy Prescription Form Overview

Complete when Formulary and OTC alternatives cannot be used.

This form is for Non-Formulary or step therapy medications. It should be completed by the prescriber and faxed to the Pharmacy Consult Service at 404-467-2731. For prior authorization medications on the Targeted Review List contact QRM at 404-364-7320 (option 3).

KAISER PERMANENTE

Non-Formulary or Step Therapy Prescription Drug Form

Fax to 404-467-2731

Member Name (print): _____

Kaiser Permanente Health Plan Number: _____ **DOB:** _____

Print or Stamp Prescriber Name:

Prescriber Phone number:

Prescriber Fax number:

Office Address:

Add individual prescriber data to create a master copy for each physician in your medical office, then copy.

Please note for criteria restricted medications (Prior Authorization) on the Targeted Review List, the provider should call Quality Resource Management at 404-364-7320 (Option 3) or fax 866-452-4585.

Paragraph reinforces to the patient that the Kaiser Permanente drug benefit covers formulary drugs.

Our Drug Formulary is developed by doctors and pharmacists who meet regularly to review and revise the formulary, considering new medicines as they become available. The Kaiser Permanente prescription drug benefit does not routinely cover medications *not* listed on our Drug Formulary. If a medication on our Drug Formulary cannot be prescribed *for medical reasons*, the prescription drug plan may cover a Non-formulary or step therapy medication. Prescribers must determine if a Formulary medication cannot be prescribed and provide all requested documentation below.

When prescribing a non-covered drug (eg. sexual dysfunction, weight loss or cosmetic use), or when a patient insists on a NF drug despite lack of an adequate trial on a Formulary alternative, check box to indicate patient is aware it's not covered and will pay full price. This

Diagnosis / Indication for Non-formulary or step therapy drug: ☐ Privileged Diagn

☐ Check here if member will pay full retail price for this Non-formulary or step therapy prescription (non-covered) & skip to prescription section below. (*If not checked, complete all sections below*)

Health Record documentation for the following exists for this pt (check all that apply):	YES	NO
Lack of efficacy with Formulary medications (*if yes, complete section below*)		
Intolerable side effects with Formulary medications (*if yes, complete section below*)		
Formulary medications contraindicated (*if yes, complete section below*)		

Formulary drugs *used or considered* for this diagnosis:

Formulary Drug Name / Dose	Describe response to treatment, or Specify type of intolerance or allergy, or List contraindication to formulary drug

Check the appropriate box(es) to indicate why Formulary drug(s) cannot be used.

Write Non-Formulary or Step Therapy Prescription Below

(***one prescription per form***, up to 30 day supply recommended for initial therapy)

Write the name of Formulary alternative(s) tried and treatment response, allergy/ intolerance or contraindication(s) to Formulary drug(s).

Rx

DEA# _____

Prescriber Signature _____

Write the Non-Formulary or step therapy prescription in this area. Please prescribe only one drug per Prescription Drug Form.