Exigent step therapy protocol exception form

Please allow 24 hours for review and response.
Responses will be faxed; therefore, a fax number must be provided.
Please fill out form completely. If any information is missing, it could result in a denial.
Approvals will only be for 28 days.

Is this request for an exigent step therapy drug (from list of non-oncology medical benefit drugs)**?**
☐ Yes ☐ No

Is this request for a member contract subject to the state law – including Arkansas Blue Cross and Blue Shield fully insured (Arkansas Blue Cross and Health Advantage) – and/or specified governmental (ASE/PSE) health plans?
☐ Yes ☐ No

If the answer to either question above is no, this form does not apply,
please go through normal process for Prior Approval requests

Date of request: _____

Requesting provider information

Doctor/Facility name		**Tax ID/NPI number**	
Address	**City**	**State**	**ZIP**
Phone number	**Fax number (required)**	**Contact person***	

* A request for exigent step therapy drugs on weekends and holidays will require contact information for the requesting provider on weekends and holidays for any additional exigent information required. Absence of this information may result in denial if required information cannot be obtained.

Patient information

Patient first name	**Middle initial**	**Last name**	
Member ID (including prefix)		**Patient date of birth** (mm/dd/yyyy)	
Patient address	**City**	**State**	**ZIP**
Policyholder name		**Plan/Group name and number**	

Rendering facility (if applicable)

Facility name		Tax ID/NPI number	
Address	**City**	**State**	**ZIP**
Phone number	**Fax number**	**Contact person**	

Service information

Scheduled service date (mm/dd/yyyy)	Duration requested*

*No more than 28 days will be approved under an exigent request.

J Code	Dosage/Units	Frequency of dosage
NDC number	**Diagnosis codes (ICD-10)**	**Continuation/Repeat service** ☐ Yes ☐ No

Medical reason for service

Submitting provider (required)

Name	Phone
Email	

Please attach medical records, labs, treatment plan or any other documentation supporting the need for the service above. (Submission of a letter requesting the drug is not adequate documentation.)

Please return this form and attached documents to:
Email: StepTherapyRequest@arkbluecross.com
or
Fax: 501-301-1960