Security Health Plan
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Step Therapy Override

Coverage Determination Request

Date ______________________

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Member address		

Provider information		
Provider name (print)	Attn	Fax number
Provider NPI		

Medication requested ____

Answer all of the following questions.

Is this a request for a step therapy (ST) exception OR an exception for step therapy requirements that are included within a PA guideline . . . . . ☐ Yes ☐ No

Has the patient had a previous trial of preferred step therapy agents . . . . . ☐ Yes ☐ No

If patient has had a trial, list the step therapy agents below:

____

____

____

Has the prescribing provider submitted complete, clinically relevant information supporting a step therapy exception request . . . . . ☐ Yes ☐ No

Have at least ONE (1) of the following conditions been met:

- The ST-required drug is contraindicated for the patient or will likely cause an adverse reaction or physical or mental harm. . . . . ☐ Yes ☐ No
- The ST-required drug is expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the prescription drug regimen . . . . . ☐ Yes ☐ No
- The patient has tried the ST-required drug, or another drug in the same pharmacologic class or with the same mechanism of action, while under the patient's current or previous health insurance plan; and the patient's use of the prescription drug was discontinued by the provider due to lack of efficacy or effectiveness, diminished effect, or adverse event. . . . . ☐ Yes ☐ No
- Based on an evaluation of medically necessary drugs for the patient's condition, the prescription drug required under the step therapy protocol is not in the best interest of the patient . . . . . ☐ Yes ☐ No
- The patient is stable on the requested drug selected by the provider for the medical condition under consideration while covered on a current or previous health insurance plan. . . . . ☐ Yes ☐ No

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By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

____ _______________
Provider signature Date

To submit step therapy override request for drugs administered in the office or medical setting, send completed form via mail or fax:

Attn: Health Services Department
Security Health Plan
PO Box 8000
Marshfield, WI 54449

Fax: 715-221-6616

You may also call our Health Services Department at 1-800-991-8109.

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