COVERAGE DETERMINATION REQUEST FORM

Slate Rx

Step Therapy Exception

Phone: 833-320-1824 Fax back to: 866-351-1617

SlateRx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions, sign and fax this form to the number listed above.

Please note any information left blank or illegible may delay the review process

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date Of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip: ,	City, State, Zip: ,	
Primary Phone:	Specialty:	

☐ Standard ☐ Expedited / Urgent

Drug Name and Strength:

Directions / SIG:

Q1. Please indicate the patient's diagnosis being treated by the requested medication.

Q2. Is the request for initial or continuing therapy? (If continuation of therapy, please include the start date - MM/YYYY)

☐ Initial therapy ☐ Continuing therapy _____

Q3. Please provide the specific alternative medications name and strength, including dates, the patient has tried and failed.

Q4. If the member has not previously tried and failed a step one medication or a formulary alternative, please indicate below why the member needs to have an exception to the step therapy.

Prescriber Signature: _____ Date: _____