SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Ulesfia™ Lotion (benzyl alcohol)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Hair Length		Amount of Ulesfia™ Lotion per Application		Recommended Number of Bottles per Application	Total Number of Bottles for Complete Treatment
Short	0-2 inches	4-6 oz.	½ - ¾ bottle	1	2
	2-4 inches	6-8 oz.	¾ - 1 bottle	1	2
Medium	4-8 inches	8-12 oz.	1- 1½ bottles	1.5	3
	8-16 inches	12-24 oz.	1½- 3 bottles	3	6
Long	16-22 inches	24 – 32 oz.	3- 4 bottles	4	8
	Over 22 inches	32-48 oz.	4- 6 bottles	6	12

(Continued on next page)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Patient has tried and failed a complete course **(administration and re-administration after 7 days)** of **one (1)** formulary OTC Permethrin 1% product **(**Family Care patients must have paid pharmacy claim for a Permethrin 1% product**)**

AND

- ❑ Patient has tried and failed generic Ovide lotion (malathion)

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

REVISED/UPDATED/REFORMATTED: ~~8/27/2017; 8/31/2018; 1/6/2020;~~ **11/10/2023**