SENTARA HEALTH PLANS

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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested (select one below):

❑ **candesartan** (Atacand®)	❑ **candesartan-HCTZ** (Atacand HCT®)
❑ **Edarbi®** (azilsartan)	❑ **Edarbyclor®** (azilsartan & chlorthalidone)
❑ **aliskiren** (Tekturna®)	❑ **Tekturna HCT®** (aliskren & hydrochlorothiazide)

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:** _____

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.

(Continued on next page)

For candesartan/HCTZ, Edarbi® and Edarbyclor® requests:

- ❑ Member has tried and failed 30 days of therapy with **at least one (1)** of the following **(verified by chart notes or pharmacy paid claims):**

❑ amlodipine-olmesartan	❑ losartan	❑ telmisartan
❑ amlodipine-valsartan	❑ losartan-HCTZ	❑ valsartan
❑ irbesartan	❑ olmesartan	❑ valsartan-HCTZ
❑ irbesartan-HCTZ	❑ olmesartan-HCTZ	

For aliskiren (Tekturna®) or Tekturna HCT® requests:

- ❑ Member has tried and failed 30 days of therapy with **at least one (1)** of the following **(verified by chart notes or pharmacy paid claims):**

❑ amlodipine-olmesartan	❑ losartan	❑ telmisartan
❑ amlodipine-valsartan	❑ losartan-HCTZ	❑ valsartan
❑ irbesartan	❑ olmesartan	❑ valsartan-HCTZ
❑ irbesartan-HCTZ	❑ olmesartan-HCTZ	

AND

- ❑ Member has tried and failed 30 days of therapy with Edarbi® or Edarbyclor®

If requesting candesartan tablets for migraine prevention:

- ❑ Provider must submit documentation to confirm indication for use

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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.*

***Approved by Pharmacy and Therapeutics Committee on:** ~~11/19/2012;~~ **5/23/2024**
REVISED/UPDATED/REFORMATTED: ~~1/19/2016; 12/16/2016; 8/12/2017; 6/10/2019; 1/6/2022; 4/25/2022; 6/15/2022; 6/16/2022; 5/17/2024~~; **6/5/2024**