

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):

<input type="checkbox"/> candesartan (Atacand®)	<input type="checkbox"/> candesartan-hydrochlorothiazide (Atacand HCT®)
<input type="checkbox"/> Edarbi ® (azilsartan)	<input type="checkbox"/> Edarbyclor ® (azilsartan-chlorthalidone)

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: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

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 & candesartan-hydrochlorothiazide requests:

- ☐ Member has tried and failed 30 days of therapy with **at least TWO (2)** of the following (select all that apply; verified by chart notes and/or pharmacy paid claims):

<input type="checkbox"/> amlodipine-olmesartan	<input type="checkbox"/> losartan	<input type="checkbox"/> telmisartan
<input type="checkbox"/> amlodipine-valsartan	<input type="checkbox"/> losartan-HCTZ	<input type="checkbox"/> valsartan
<input type="checkbox"/> irbesartan	<input type="checkbox"/> olmesartan	<input type="checkbox"/> valsartan-HCTZ
<input type="checkbox"/> irbesartan-HCTZ	<input type="checkbox"/> olmesartan-HCTZ	

If requesting candesartan tablets for migraine prevention:

- ☐ Provider must submit documentation to confirm indication for use

For Edarbi & Edarbyclor requests:

- ☐ Member has tried and failed 30 days of therapy with **at least THREE (3)** of the following (select all that apply; verified by chart notes and/or pharmacy paid claims):

<input type="checkbox"/> amlodipine-olmesartan	<input type="checkbox"/> losartan	<input type="checkbox"/> telmisartan
<input type="checkbox"/> amlodipine-valsartan	<input type="checkbox"/> losartan-HCTZ	<input type="checkbox"/> valsartan
<input type="checkbox"/> irbesartan	<input type="checkbox"/> olmesartan	<input type="checkbox"/> valsartan-HCTZ
<input type="checkbox"/> irbesartan-HCTZ	<input type="checkbox"/> olmesartan-HCTZ	

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.****