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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

The Sentara Health Plans Oncology Program is administered by OncoHealth

- **For any oncology indications**, the most efficient way to submit a prior authorization request is through the **OncoHealth OneUM Provider Portal** at https://oneum.oncohealth.us. Fax to **1-800-264-6128.** OncoHealth can also be contacted by Phone: 1-888-916-2616.
- Commercial customers **NOT** enrolled in the OncoHealth program, please fax requests to Sentara Health plans at fax number 1-800-750-9692.

Erythropoiesis Stimulating Agents (ESAs) *For Non-Dialysis Use*

This form is to be completed ONLY if the patient is self-administering

Drug Requested: (check one below)

❑ **Aranesp®** (darbepoetin alfa)	❑ **Epogen®** (epoetin alfa)	❑ **Mircera®** (methoxy polyethylene glycol-epoetin beta)
❑ **Procrit®** (epoetin alfa)	❑ **Retacrit™** (epoetin alfa-epbx)	

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 Form/Strength: _____

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

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

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

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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.

❑ Diagnosis: Anemia Due to Chronic Kidney Disease

Initial Authorization: 6 months

- ❑ Member has a documented diagnosis of anemia due to chronic kidney disease (CKD)
- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member must meet **ONE** of the following hemoglobin requirements:
    - ❑ Member is an adult with a hemoglobin level <10 g/dL
    - ❑ Member is a pediatric patient who is symptomatic with a hemoglobin level <11 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%
- ❑ Member is **NOT** receiving hemodialysis
- ❑ All other causes of anemia have been ruled out (e.g., iron, vitamin B12 or folate deficiency, hemolysis)

❑ Diagnosis: Anemia Due to Chronic Kidney Disease

Reauthorization: 6 months. Check below all that apply. All criteria must be checked 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.

- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member's hemoglobin level ≤ 12 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%

❑ Diagnosis: Anemia of Prematurity

Length of Authorization: 6 months

- ❑ Documentation of **ALL** the following must be submitted:
  - ❑ Medication will be used in combination with iron supplementation
  - ❑ Member must meet **ONE** of the following:
    - ❑ Member's birth weight <1500 grams
    - ❑ Member's gestational age <33 weeks

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❑ Diagnosis: Anemia Due to Myelosuppressive Medication Regimen for HIV

Initial Authorization: 6 months

- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member must meet **ONE** of the following hemoglobin requirements:
    - ❑ Member is an adult with a hemoglobin level <10 g/dL
    - ❑ Member is a pediatric patient who is symptomatic with a hemoglobin level <11 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%
  - ❑ Member's serum erythropoietin level ≤ 500 milliunits/mL
- ❑ Member is being treated with an HIV medication regimen that includes zidovudine (≤ 4200mg/week)
- ❑ All other causes of anemia have been ruled out (e.g., iron, vitamin B12 or folate deficiency, hemolysis)

❑ Diagnosis: Anemia Due to Myelosuppressive Medication Regimen for HIV

Reauthorization: 6 months. Check below all that apply. All criteria must be checked 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.

- ❑ Member continues to receive an HIV medication regimen that includes zidovudine (≤ 4200 mg/week)
- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member's hemoglobin level ≤12 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%
  - ❑ Member's serum erythropoietin level ≤ 500 milliunits/mL

❑ Diagnosis: Anemia Due to Myelosuppressive Medication Regimen for Hepatitis C

Initial Authorization: 6 months

- ❑ Member has a documented diagnosis of anemia
- ❑ Member is being treated with a myelosuppressive regimen (e.g., ribavirin with interferon or peginterferon) for the treatment of Hepatitis C
- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member must meet **ONE** of the following hemoglobin requirements:
    - ❑ Member is an adult with a hemoglobin level <10 g/dL
    - ❑ Member is a pediatric patient who is symptomatic with a hemoglobin level <11 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%

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- ❑ All other causes of anemia have been ruled out (e.g., iron, vitamin B12 or folate deficiency, hemolysis)

❑ Diagnosis: Anemia Due to Myelosuppressive Medication Regimen for Hepatitis C

Reauthorization: 6 months. Check below all that apply. All criteria must be checked 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.

- ❑ Member continues to receive a myelosuppressive regimen for the treatment of Hepatitis C
- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member's hemoglobin level ≤12 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%

❑ Diagnosis: Reduction of Allogenic Red Blood Cell Transfusions in Patients Undergoing Elective, Noncardiac, Nonvascular Surgery

Length of Authorization: 3 months

- ❑ Requested drug will be used to decrease the need for blood transfusion in a surgery patient
- ❑ Member is scheduled to undergo surgery within the next three (3) months
- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member's hemoglobin level <13 g/dL
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%
- ❑ All other causes of anemia have been ruled out (e.g., iron, vitamin B12 or folate deficiency, hemolysis)

❑ Diagnosis: All Other Indications

Length of Authorization: 6 months

- ❑ Member's diagnosis of anemia and/or risk factors for development of anemia must be noted in submitted chart notes for medical necessity approval
- ❑ Provider must document requested length of therapy: _____
- ❑ Provider must submit documentation of **ALL** the following test results obtained **within the last 30 days**:
  - ❑ Member's current hemoglobin level: _____
  - ❑ Member's serum ferritin ≥ 100 ng/mL (mcg/L)
  - ❑ Member's transferrin saturation (TSAT) ≥ 20%
  - ❑ If applicable, any other test results to support medical necessity approval
- ❑ All other causes of anemia have been ruled out (e.g., iron, vitamin B12 or folate deficiency, hemolysis)

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Medication being provided by Specialty Pharmacy – Proprium Rx

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:** ~~7/20/2012;~~ **1/18/2024**
REVISED/UPDATED/REFORMATTED: ~~5/21/2015; 12/24/2015; 8/13/2016; 9/22/2016; 12/11/2016; 8/2/2017; 3/5/2019; 8/14/2019; 2/9/2024;~~ **2/28/2025**