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: Hemangeol® (propranolol HCl) **oral solution**

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:** _____

Dosing Regimen: 0.15 mL/kg (0.6 mg/kg) twice daily, increase to 0.3 mL/kg (1.1 mg/kg) twice daily after 1 week, then to a maintenance dose of 0.4 mL/kg (1.7 mg/kg) twice daily

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.

Initial Authorization: 6 months

- ❑ Member has a diagnosis of proliferating infantile hemangioma
- ❑ Member's age range is between 5 weeks and 5 months
- ❑ Member weighs at least 2 kilograms
- ❑ Provider attests the member does NOT have any of the following contraindications to therapy:
  - ❑ Known hypersensitivity to propranolol or excipients
  - ❑ Asthma or history of bronchospasm
  - ❑ Bradycardia (heart rate < 80 beats/minute)

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- ❑ Greater than first degree heart block
- ❑ Decompensated heart failure
- ❑ Blood pressure < 50/30 mmHg
- ❑ Pheochromocytoma

Reauthorization Approval: 6 months. 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.

- ❑ Member continues to meet all initial request criteria
- ❑ Member has previously been successfully treated with Hemangeol for 6 months resulting in complete or nearly complete resolution of the target hemangioma but has experienced a recurrence

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.****