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: Select one drug below

❑ **Ridaura® (auranofin) 3 mg capsules**	❑ **Auranofin 3 mg capsules**

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:** _____

Quantity Limit: 3 capsules per day

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.

- ❑ Member is 18 years of age or older
- ❑ Medication has been prescribed by or in consultation with a Rheumatologist
- ❑ Member has a diagnosis of rheumatoid arthritis
- ❑ Provider must submit documentation of CBC with differential, platelet count, urinalysis, and renal and liver function tests which are to be obtained prior to auranofin therapy to establish a baseline and identify any preexisting conditions **(submit labs)**

(Continued on next page)

- Member has had an unsuccessful 30-day trial and failure of at least **TWO (2)** nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., celecoxib, diclofenac, ibuprofen, meloxicam, naproxen **(verified by chart notes and/or pharmacy paid claims)**
- Member has had an unsuccessful 30-day trial and failure of at least **TWO (2)** disease modifying antirheumatic drugs (DMARDs) (e.g., methotrexate, leflunomide, hydroxychloroquine) **(verified by chart notes and/or pharmacy paid claims)**
- Provider attests that labs and other parameters will be monitored as appropriate and that the member will be periodically assessed for signs of possible gold toxicity (e.g., hemoglobin, leukopenia below 4,000 WBC/cu mm, granulocytes below 1,500/cu mm, decrease in platelets below 150,000/cu mm, proteinuria, hematuria, pruritus, rash, stomatitis or persistent diarrhea)

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.*