# SENTARA COMMUNITY PLAN
# (MEDICAID)

## MEDICAL 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 1-844-305-2331**. 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 can be delayed**.

**Drug Requested: Kybella®** (deoxycholic acid) **IV (J0591) (Medical)**

**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:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

**Coverage Duration**: One time authorization; Maximum 6 treatments, spaced at ≥ 1-month intervals per treatment (50 injections per treatment spaced 1 cm apart [0.2 mL each; total 10 mL])

**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.

**Length of Authorization: Date of Service**

- ❑ Member is ≥ 18 years and ≤ 65 years old
- ❑ Prescribed by or in consultation with a dermatologist, or a specialist in submental contouring

**(Continued on next page)**

- ❑ Member has a BMI ≤ 40 kg/m$^2$
- ❑ Member's body weight has been stable for at least 6 months
- ❑ Member has been assessed to have at least moderate convexity or fullness associated with submental fat tissue (i.e., grade 2 or 3 on 5-point grading scales, where 0 = none and 4 = extreme) **[Submit the Clinician-Reported Submental Fat Rating Scale (CR-SMFRS), the Patient-Reported Submental Fat Rating Scale (PR-SMFRS), AND the Submental Skin Laxity Grade (SMSLG)]**

  **NOTE:** Members are precluded from treatment if they have grade 4 on the Submental Skin Laxity Grade or if an anatomical feature (e.g., predominant postplatysmal fat, loose skin in the neck/chin area, prominent platysmal bands) will result in an unacceptable outcome
- ❑ Member has **NOT** undergone any of the following treatments:
  - Radiofrequency, lasers, chemical peels, or dermal fillers in neck/chin within 12 months
  - Botulinum toxin injections in neck/chin within 6 months
  - History of liposuction, surgery, or treatment with lipolytic agents
- ❑ Member does **NOT** have a clinically significant bleeding disorder

**Medication being provided by: Please check applicable box below.**

- ❑ **Location/site of drug administration:** _____

  **NPI or DEA # of administering location:** _____

  **OR**
- ❑ **Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

***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.***