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

❑ **Enbumyst™** (bumetanide)	❑ **Furoscix®** (furosemide)	❑ **Lasix® ONYU** (furosemide)

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:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy

Quantity Limit:

- Embumyst: Up to a 90-day supply, based on the prescribed dose
- Furoscix: 3 units per 90 days
- Lasix Onyu: 3 units per 90 days

(Continued on next page)

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: 3 months

- ❑ Prescriber attestation that a non-oral route of administration of a loop diuretic is medically necessary for the treatment of edema
- ❑ Prescriber attestation that the member will be monitored on an outpatient basis for fluid, electrolyte, and metabolic abnormalities
- ❑ Prescriber attestation that this medication is intended for short-term use only and that the member will be transitioned to oral diuretic therapy as soon as clinically appropriate
- ❑ **Additional criteria for Enbumyst**
  - ❑ Member is 18 years or older
  - ❑ Member has edema associated with congestive heart failure, hepatic disease, or renal disease, including nephrotic syndrome
  - ❑ Member does not have anuria, hepatic coma or acute pulmonary edema
- ❑ **Additional criteria for Furoscix**
  - ❑ Member is 6 years or older
  - ❑ Member weighs ≥ 43 kg
  - ❑ Member has edema associated with chronic heart failure or chronic kidney disease, including the nephrotic syndrome
  - ❑ Member does not have anuria or hepatic cirrhosis or ascites or acute pulmonary edema
- ❑ **Additional criteria for Lasix Onyu**
  - ❑ Member is 18 years or older
  - ❑ Member has edema associated with chronic heart failure
  - ❑ Member does not have anuria, hepatic cirrhosis, ascites, or acute pulmonary edema

*****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**: ~~2/16/2023; 9/26/2024; 3/27/2025;~~ **5/22/2025**
REVISED/UPDATED/REFORMATTED: ~~3/09/2023; 10/15/2024,4/15/2025; 06/09/2025, 3/26/2026;~~ **10/16/2026**