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.**

Potassium Binders

Drug Requested: (select one from below)

❑ **Lokelma®** (sodium zirconium cyclosilicate)	❑ **Veltassa®** (patiromer)

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:** _____

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: 12 months

- ❑ Member must meet **ONE** of the following age indications for use:
  - ❑ **For Lokelma requests:** Member is 18 years of age or older
  - ❑ **For Veltassa requests:** Member is 12 years of age or older

(Continued on next page)

- ❑ Member has a diagnosis of **chronic** non-life threatening hyperkalemia
- ❑ Provider has submitted laboratory documentation of serum potassium levels supporting hyperkalemia **(baseline serum potassium >5.0 mEq/L)**
- ❑ Prescriber attests if clinically appropriate, member has tried and failed loop or thiazide diuretic therapy for potassium removal
- ❑ Member is **NOT** on concurrent or dual therapy with another potassium binder
- ❑ Member has been counseled to follow a low potassium diet (≤ to 3 g/day)
- ❑ If clinically appropriate, medications known to cause hyperkalemia (e.g., angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, aldosterone antagonist) have been discontinued, **OR** if no therapeutic alternative to these medications exist, reduce to the lowest effective dose as clinically appropriate for members with diagnoses such as chronic kidney disease and congestive heart failure **(submit documentation)**

Reauthorization: 12 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.

- ❑ Provider attests serum potassium levels continue to be monitored
- ❑ Provider has submitted documentation to support clinical benefit from treatment (e.g., potassium level returned to normal significant decrease from baseline), and member continues to require treatment for hyperkalemia

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.*