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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

The Sentara Health Plans Oncology Program is administered by OncoHealth

- **For any oncology indications**, the most efficient way to submit a prior authorization request is through the **OncoHealth OneUM Provider Portal** at https://oneum.oncohealth.us. Fax to **1-800-264-6128.** OncoHealth can also be contacted by Phone: 1-888-916-2616.
- Commercial customers **NOT** enrolled in the OncoHealth program, please fax requests to Sentara Health plans at fax number 1-800-750-9692.

Drug Requested: (Select one from below)

❑ **metyrosine** (Demser®)	❑ **phenoxybenzamine** (Dibenzyline®)

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:** _____

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.

(Continued on next page)

- ❑ Member must have a diagnosis of pheochromocytoma

AND

- ❑ Provider must submit documentation to confirm resection of the pheochromocytoma is planned or resection of the tumor is contraindicated or has been unsuccessful

AND

- ❑ Member must have trial and failure of a selective alpha-blocker e.g., doxazosin, prazosin, terazosin **(verified by chart notes and/or pharmacy paid claims)**

AND

- ❑ If requesting generic metyrosine (Demser®), trial and failure of generic phenoxybenzamine is required **(verified by chart notes and/or pharmacy paid claims)**

AND

- ❑ If requesting brand Demser®, trial and failure of generic metyrosine **AND** phenoxybenzamine is required **(verified by chart notes and/or pharmacy paid claims)**

AND

- ❑ If requesting brand Dibenzyline®, trial and failure of generic phenoxybenzamine is required **(verified by chart notes and/or pharmacy paid claims)**

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.****