

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.**

Drug Requested: (Select one from below)

metyrosine (Demser®)

phenoxybenzamine (Dibenzylamine®)

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.

- 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

(Continued on next page)

- ❑ 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 Dibenzyl[®], 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.