

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: Exxua™ (gepirone)

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: _____

Recommended Dosage: One tablet per day. Maximum dosage: 72.6 mg once daily.

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 is 18 years of age or older and meets **ONE** of the following dosing requirements:
 - 18 to 64 years of age, maximum daily dose is 72.6 mg per day
 - ≥ 65 years of age, maximum daily dose is 36.3 mg per day
- Prescribed by or in consultation with a mental health clinician
- Member has a diagnosis of major depressive disorder (MDD) as defined by DSM-5 criteria and/or appropriate depression rating scale (e.g. PHQ-9, Clinically Useful Depression Outcome Scale, Quick Inventory of Depressive Symptomatology-Self Report 16 Item, MADRS, HAM-D) (**scale must be attached**)

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- ❑ Member has failed non-pharmacological interventions such as cognitive behavioral therapy or interpersonal psychotherapy (**submit documentation**)
- ❑ Provider attests that member has been screened for personal and/or family history of bipolar disorder, mania, and hypomania
- ❑ Provider attests an electrocardiogram (ECG) will be performed before starting treatment, during dosage titration, and periodically during treatment
- ❑ Provider attests electrolyte abnormalities will be corrected prior to initiation
- ❑ Provider attests members with electrolyte abnormalities, who are receiving diuretics or glucocorticoids, or have a history of hypokalemia or hypomagnesemia will be monitored during dose titration and periodically during treatment
- ❑ Member does **NOT** have any of the following:
 - Hypersensitivity to gepirone or any component of the requested medication
 - Prolonged QTc interval greater than 450 msec
 - Congenital long QT syndrome
 - Use of strong CYP3A4 inhibitors
 - Severe liver problems
- ❑ Member will **NOT** take a monoamine oxidase inhibitor (MAOI) within 14 days of taking Exxua™
- ❑ Member has tried and failed **THREE (3)** formulary antidepressants, including one (1) selective serotonin reuptake inhibitor (SSRI), one (1) serotonin-norepinephrine reuptake inhibitor (SNRI), and one (1) other agent (e.g., bupropion, mirtazapine, TCA) for at least **30 days** (**verified by chart notes and/or pharmacy paid claims**)
- ❑ Member has tried and failed **ONE (1)** other pharmacotherapy for combination or augmentation (e.g., lithium, liothyronine, buspirone, antipsychotics, anticonvulsants) for at least **30 days** (**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.