SENTARA HEALTH PLANS

MEDICAL 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 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Jesduvroq (daprodustat) **J0889 MEDICAL**

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Strength	Maximum number of tablets per day	# Billable units per day	# Billable units per 30 days
1 mg	1 tablet per day	1 billable unit	30 billable units
2 mg	1 tablet per day	2 billable units	60 billable units
4 mg	1 tablet per day	4 billable units	120 billable units
6 mg	2 tablets per day	12 billable units	360 billable units
8 mg	3 tablets per day	24 billable units	720 billable units

(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: 6 months

- ❑ Member is 18 years of age or older
- ❑ Medication is prescribed by or in consultation with a nephrologist
- ❑ Member has a diagnosis of anemia due to chronic kidney disease (CKD) and has been receiving dialysis for at least 4 months
- ❑ Provider attests other causes of anemia have been ruled out (e.g., vitamin deficiency, metabolic or chronic inflammatory conditions, bleeding)
- ❑ Member's hemoglobin level is less than 10g/dL **(must submit lab test results from within the last 30 days)**
- ❑ Member's labs show adequate iron stores with **BOTH** of the following **(must submit lab test results from within the last 30 days)**:
  - ❑ Transferrin saturation is at least 20%
  - ❑ Ferritin is at least 100 mcg/L
- ❑ Member has tried and failed an erythropoiesis stimulating agent (ESA) for at least 4 weeks **(must submit chart notes and/or lab test results documenting therapy failure)**
- ❑ Member will **NOT** be using the requested medication in combination with an ESA (e.g., Aranesp®, Epogen®, Mircera®, Procrit®, Retacrit®)
- ❑ Member does **NOT** have uncontrolled hypertension
- ❑ Member does **NOT** have severe hepatic impairment (Child-Pugh Class C)
- ❑ Member does **NOT** have active malignancy
- ❑ Member has **NOT** experienced a myocardial infarction, cerebrovascular event, or acute coronary syndrome within the last 3 months
- ❑ Member is **NOT** taking a strong cytochrome P450 (CYP) 2C8 inhibitor (e.g., gemfibrozil)

Reauthorization: 6 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.

- ❑ Member's hemoglobin has increased compared to baseline **(must submit lab test results from within the last 30 days)**
- ❑ Member's current hemoglobin level does **NOT** exceed 12 g/dL
- ❑ Member will **NOT** be using the requested medication in combination with an ESA (e.g., Aranesp®, Epogen®, Mircera®, Procrit®, Retacrit®)

(Continued on next page)

Medication being provided by (check applicable box(es) below):

- ❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

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**: 11/16/2023
REVISED/UPDATED: ~~11/8/2023;~~ ~~12/11/2023~~**; 2/06/2024**