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.**

Drug Requested: Compound Drug(s)

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 #: _____

Ingredients:

Drug	Strength	Drug	Strength

The Compound **must** contain at least **one FDA-approved** prescription drug and the prescription ingredients **must** be in therapeutic amounts recognized by national compendia or peer-reviewed medical literature.

Indication: _____

Dosage form of compound: _____

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.

- ❑ National Compendia reference or two (2) peer-reviewed randomized controlled trials supporting the efficacy and safety of this compound are attached to this request.

AND

(Continued on next page)

- ❑ Patient has tried and failed at least three (3) FDA-approved commercially available therapeutic alternatives and at least one of the alternatives is of the same route of administration as the compound:
  - ❑ Drug: _____ Route of administration: _____
  - ❑ Drug: _____ Route of administration: _____
  - ❑ Drug: _____ Route of administration: _____

AND

- ❑ The strength requested is **not** commercially available

Compounds containing the following must be in the same dosage form as commercially available specific drug products: diclofenac, flurbiprofen, fluticasone, gabapentin, ketamine, ketoprofen, levoceterizine and mometasone.

Compounds used for cosmetic indications are excluded from benefit and will be denied

*****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.****