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 information provided is not complete, correct, or legible, authorization may be delayed.**

Non-Preferred Albuterol Inhalers

Drug Requested: (select one below)

❑ **levalbuterol HFA** (Xopenex® ABA)	❑ **Ventolin HFA®** (albuterol sulfate)
❑ **Proventil® HFA** (albuterol sulfate)	❑ **Xopenex HFA** (levalbuterol)

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 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.

❑ **For Approval of any non-preferred albuterol/levalbuterol inhaler:**

- ❑ Member must have an intolerance or contraindication to generic albuterol HFA inhaler

AND

(Continued on next page)

- ❑ Provider **MUST** submit clinical chart notes or a completed MedWatch form documenting the experienced treatment failure with generic albuterol HFA inhaler

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.****

***Approved by Pharmacy and Therapeutics Committee:** ~~3/21/2019;~~ **9/15/2022**
REVISED/UPDATED/REFORMATTED: ~~3/29/2019; 6/27/2019; 8/13/2019; 10/17/2022;~~ **8/6/2026**