

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: Baxfendy™ (baxdrostat)

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 Dosing: Oral: 2 mg once daily. Patients at increased risk of hyperkalemia or hyponatremia:
Oral: 1 mg once daily.

Quantity Limit: 1 tablet per day

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: 12 months

☐ Member is 18 years of age or older

(Continued on next page)

- ❑ Member is currently receiving treatment at maximum or maximally tolerated doses with at least **ONE** agent from each of the classes below, unless contraindicated, for the past 4 weeks (**verified by pharmacy paid claims; documentation of intolerances or contraindications must be submitted; check all that apply**)
 - ❑ Renin-angiotensin system (RAS) inhibitors (e.g., lisinopril, enalapril, losartan, valsartan)
 - ❑ Calcium channel blockers (e.g., amlodipine, felodipine, nifedipine, verapamil)
 - ❑ Thiazide/thiazide-like diuretics (e.g., hydrochlorothiazide, chlorthalidone, indapamide)
- ❑ Treatment with a mineralocorticoid receptor antagonist (spironolactone, eplerenone) has been added to the existing antihypertensive regimen and was ineffective, intolerable, or is contraindicated (**verified by pharmacy paid claims; documentation of intolerance or contraindication must be submitted**)
- ❑ Treatment with an additional antihypertensive agent with a different mechanism of action (e.g., hydralazine, minoxidil, clonidine, prazosin, metoprolol) has been ineffective, or are all contraindicated (**verified by pharmacy paid claims; documentation of intolerance or contraindication must be submitted**)
- ❑ Member has resistant hypertension as demonstrated by blood pressure $\geq 130/80$ mmHg despite adherence to the prescribed antihypertensive drug regimen (**submit documentation of blood pressure reading recorded within 30 days of request**)
- ❑ Member has been adherent to prescribed antihypertensive drug regimen for at least 4 weeks prior to the date of the blood pressure reading recorded in chart note documentation (**adherence will be verified by pharmacy paid claims**)
- ❑ Provider has evaluated the member for causes of pseudo-resistance (e.g., inaccurate blood pressure readings, white coat hypertension, secondary hypertension, non-adherence to medication) and confirms that pseudo-resistant hypertension has been ruled out
- ❑ Member will **NOT** use Baxfendy concomitantly with any of the following other medications: mineralocorticoid receptor antagonists, non-steroidal mineralocorticoid receptor antagonists, potassium-sparing diuretics, direct renin inhibitors, or aprocitentan
- ❑ Provider attests baseline serum potassium and serum sodium have been obtained and will be monitored periodically or as clinically indicated

(Continued on next page)

Reauthorization: 12 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 blood pressure has reduced from baseline after initiating therapy with Baxfendy™ (**submit documentation**)
- ☐ Member is adherent to Baxfendy™ and continues to receive Baxfendy™ in addition to background antihypertensive drug therapy (**verified by pharmacy paid claims**)
- ☐ Provider attests serum potassium and serum sodium continue to be monitored

Medication being provided by Specialty Pharmacy – Proprium Rx

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.****

;