## SENTARA HEALTH PLAN

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

<u>Directions</u>: <u>The prescribing physician must sign and clearly print name (preprinted stamps not valid)</u> on this request. All other information may be filled in by office staff; <u>fax to 1-800-750-9692</u>. No additional phone calls will be necessary if all information (<u>including phone and fax #s</u>) on this form is correct. <u>If the information provided is not complete, correct, or legible, the authorization process may be delayed.</u>

**<u>Drug Requested</u>**: pimecrolimus cream 1% (Elidel®)

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 d	lelayed if incomplete.
Drug Form/Strength:	
Dosing Schedule:	
Diagnosis:	ICD Code, if applicable:
<b>CLINICAL CRITERIA:</b> Check below all that appropriate support each line checked, all documentation, including provided or request may be denied.	
☐ Member must have at least a 30-day trial and failu	are of ONE (1) of the following (verified by erance or treatment failure must be submitted):

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. \*