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 may be delayed.**

Irritable Bowel Disease (IBD) (NON-PREFERRED) (Commercial Only)

DRUG REQUESTED - Check box below that applies:	
❑ **Mesalamine DR 800mg** (generic Asacol® HD)	❑ **Dipentum®** (olsalazine)
❑ **budesonide ER 9mg** (generic Uceris®)	❑ **Uceris®** (budesonide ER 9mg)

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:** _____

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.

❑ **Approval of mesalamine DR 800mg (generic Asacol® HD)**

- ❑ Member has had trial and failure of **at least 30 days of therapy** with mesalamine 0.375gm (generic Apriso®), mesalamine 400mg (generic Delzicol®) or mesalamine 1.2gm (generic Lialda®)

❑ **Approval of Dipentum® (olsalazine)**

(Continued on next page)

- ❑ Member has had trial and failure of **at least 30 days of therapy** with generic balsalazide (at doses recommended for treatment of ulcerative colitis[UC]) or sulfasalazine (at doses recommended for UC & Crohn's disease)

❑ For maximum 8-week approval of budesonide ER 9mg (Uceris®)

- ❑ Medication is being requested for induction of remission in member with active mild to moderate ulcerative colitis
- ❑ Member has had trial and failure of **at least 30 days of therapy** with delayed-release budesonide 3mg capsules taken at a dose of 9mg/day

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.****