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.**

Inflammatory Bowel Disease (IBD) Drugs

Drug Requested: Select one below

❑ **budesonide ER 9mg** (generic Uceris®)	❑ **Dipentum®** (olsalazine)	❑ **Mesalamine DR 800mg** (generic Asacol® HD)

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:** _____

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 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

AND

(Continued on next page)

- ❑ Member had had trial and failure of **at least 30 days of therapy** with **ONE** of the following:
  - ❑ Oral generic 5-aminosalicylate product (e.g., balsalazide, sulfasalazine)
  - ❑ Oral generic mesalamine product (e.g., generic Apriso, Delzicol, Lialda, Pentasa)
  - ❑ Oral corticosteroids (e.g., 40-60 mg prednisone)

❑ Approval of Dipentum® (olsalazine)

- ❑ 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)

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

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

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:** ~~10/19/2017;~~ **9/26/2024**
REVISED/UPDATED/REFORMATTED: ~~12/13/2017~~; ~~2/16/2018~~; ~~1/30/2019~~; ~~8/13/2019; 8/31/2020;~~ **10/28/2024**