SENTARA COMMUNITY PLAN
(MEDICAID)

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: Qbrexza® (glycopyrronium) **cloth**

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 Dosage: Apply to each underarm not more frequently than once every 24 hours using a single cloth

Quantity Limits: 30 towelettes per 30 days

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. Check box below for the Diagnosis that applies.

Initial Authorization: 12 months

- ❑ Member is ≥ 9 years of age
- ❑ Member has a diagnosis of Primary Axillary Hyperhidrosis **AND** hyperhidrosis is significantly interfering with the ability to perform age-appropriate activities of daily living
- ❑ Provider has excluded secondary causes of hyperhidrosis

(Continued on next page)

- ❑ Member must meet **ONE** of the following (**verified by chart notes and/or pharmacy paid claims**):
  - ❑ Member must have an adequate trial and failure of **ONE (1) prescription strength a**luminum chloride-containing topical antiperspirant **for at least 4 weeks and experienced inadequate efficacy** (e.g., **Drysol** (aluminum chloride 20% topical solution))
  - ❑ Member has tried and experienced significant intolerance with an aluminum-containing topical antiperspirant

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 is compliant with therapy **(verified by chart notes and/or pharmacy paid claims)**
- ❑ Member has experienced a positive response to therapy (e.g., decreased axillary sweating) **(submit documentation)**

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**: **9/26/2024**
REVISED/UPDATED/REFORMATTED: **10/11/2024**