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 information provided is not complete, correct, or legible, authorization can be delayed.**

Drug Requested: Pulmozyme® (dornase alfa) **inhalation solution**

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/Quantity: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

Maximum Approved Dose: 2.5mg single use ampule inhaled once daily using selected nebulizers. Some patients may benefit from twice-daily administration. Maximum Quantity: 150ml per 30 days (60 ampules 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.

Initial Authorization: 12 months

- ❑ Member must be 3 months of age or older with a diagnosis of Cystic Fibrosis **(must submit chart notes)**

AND

- ❑ Prescribing physician is a pulmonologist or has consulted with a pulmonologist who specializes in the treatment of Cystic Fibrosis

AND

(Continued on next page)

- ❑ Medication will be used in conjunction with standard Cystic Fibrosis therapies (e.g., oral/inhaled/parenteral antibiotics, inhaled hypertonic saline, chest physiotherapy, bronchodilators, enzyme supplements/vitamins, oral or inhaled corticosteroids)

AND

- ❑ Requests for twice daily dosing- Provider must submit documentation of an inadequate trial of once daily dosing and the member has demonstrated one or more of the following:
  - ❑ Increased pulmonary exacerbations
  - ❑ Increased hospitalization rate
  - ❑ Inability to stabilize lung function as measured by FEV1
  - ❑ Decrease in quality of life

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.

- ❑ Medication will continue to be used in conjunction with standard Cystic Fibrosis therapies (e.g. oral/inhaled/parenteral antibiotics, inhaled hypertonic saline, chest physiotherapy, bronchodilators, enzyme supplements/vitamins, oral or inhaled corticosteroids)

AND

- ❑ Member has demonstrated disease response to therapy as indicated by improvement or stability of disease symptoms by one or more of the following **(must submit chart notes)**:
  - ❑ Decreased pulmonary exacerbations
  - ❑ Decrease in hospitalization rate
  - ❑ Stabilization of lung function as measured by FEV1
  - ❑ Improvement in quality of life

Medication being provided by a Specialty Pharmacy - PropriumRx

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.****