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.**

Drug Requested: Zorbtive® (somatropin)

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 Length: 4 weeks

- ❑ Member is ≥18 years of age and has diagnosis of short bowel syndrome

AND

- ❑ Zorbtive® is being prescribed for use in conjunction with optimal management of short bowel syndrome, including intravenous parenteral nutrition, IV fluids and micronutrient supplements

AND

- ❑ Zorbtive® is being prescribed by or in conjunction with a gastroenterologist or nutritional support specialist

AND

(Continued on next page)

- ❑ Number of weeks of Zorbtive® therapy that the member has received in his or her lifetime must be noted:

  _____ weeks

AND

- ❑ Dose will not exceed maximum recommended dosing of 0.1 mg/kg once daily for 4 weeks (max 8mg per day)

AND

- ❑ Member does not have any contraindications to use of the requested medication, including diagnosis of active neoplasia (new or recurrent) or acute critical illness

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 pha rmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** 5/21/2020
REVISED/UPDATED: ~~8/31/2020;~~ **10/27/2023**