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: Oral Antifungals (Non-Preferred)

All Non-Preferred Medications Require a Prior Authorization			
❑ Ancobon®	❑ Brexafemme®	❑ Clotrimazole (mucous mem)	❑ Cresemba®
❑ Diflucan® tab/susp	❑ flucytosine	❑ Gris-Peg®	❑ griseofulvin-ultramicrosize
❑ itraconazole	❑ itraconazole-solution (generic for Sporanox® soln)	❑ ketoconazole	❑ Lamisil® tab/ granules
❑ Noxafil® (posaconazole) ❑ Noxafil® Powdermix	❑ Posaconazole tab (generic for Noxafil®)	❑ Sporanox® cap/soln	❑ Tolsura™
❑ Vfend® tab/ susp	❑ Vivjoa® (osteseconazole) (See Vivjoa® PA form)	❑ voriconazole tab	❑ voriconazole powder for susp

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:** _____

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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.

1. Has the member tried and failed **any** of the **Preferred Oral** Antifungals? ❑ Yes ❑ No

   Check below **ALL** that apply **(submit ALL supporting documentation of drug regimen and therapeutic failure):**

❑ fluconazole tab/susp	❑ nystatin tab/susp
❑ Griseofulvin® susp/tab	❑ terbinafine

2. Does the member have any contraindications or intolerances to any of the **Preferred** drugs listed in Question 1? ❑ Yes ❑ No

   If **YES**, document the specialty: _____

3. Does the member have a diagnosis for which none of the **Preferred Oral** Antifungals are indicated or widely medically-accepted? ❑ Yes ❑ No

   Check below **ALL** that apply or indicate diagnosis:

❑ aspergillosis	❑ blastomycosis	❑ cryptococcosis
❑ coccidioidomycosis	❑ febrile neutropenia	❑ histoplasmosis
❑ mucormycosis	❑ fungal infection caused by S. apiospermum or Fusarium species, including F. solani	
❑ Other (specify): _____		

4. Submit documentation of diagnosis and planned duration of treatment.

   _____

   _____

   _____

❑ **For Cresemba® approval, the following criteria must be met:**

1. The member is ≥ 18 years old? ❑ Yes ❑ No
2. Does the member have a diagnosis of invasive aspergillosis, and the member has a documented trial and failure, or contraindication, to voriconazole therapy **(require prior authorization)** as first line therapy? **OR** ❑ Yes ❑ No
3. Does the member have a diagnosis of mucormycosis? ❑ Yes ❑ No

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.

REVISED/UPDATED/REFORMATTED: ~~6/29/2017; 8/28/2017; 8/16/2018; 11/10/2018; 11/13/2018; 12/11/2018; 6/2/2019; 6/27/2022; 6/23/2023; 7/10/2023;9/14/2023; 12/21/2023;~~ **1/18/2024**