SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL 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 1-844-305-2331**. 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: Amphotericin B liposome **(AmBisome®) (J0289) (Medical)**

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:** _____

- ❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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: 3 months

- ❑ Prescribed by or in consultation with an infectious disease and/or transplant specialist
- ❑ Member has **ONE** of the following diagnoses:
  - ❑ Cryptococcal meningitis in patients with HIV
  - ❑ Febrile neutropenic patients with presumed fungal infection
  - ❑ Systemic infections caused by Aspergillus, Candida, and/or Cryptococcus
  - ❑ Visceral leishmaniasis

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- ❑ Member must meet **ONE** of the following **(verified by chart notes or pharmacy paid claims)**:
  - ❑ Member is refractory to conventional amphotericin B deoxycholate therapy
  - ❑ Member has renal impairment or unacceptable toxicity precludes the use of the deoxycholate formulation
- ❑ Member has tried and failed **ONE** of the following therapies if applicable as first-line therapy to a selected diagnosis above **(verified by chart notes or pharmacy paid claims)**:
  - ❑ flucytosine ***requires PA*** (e.g., cryptococcal meningitis in patients with HIV)
  - ❑ voriconazole (e.g., systemic infections caused by Aspergillus)
  - ❑ posaconazole ***requires PA*** (e.g., systemic infections caused Cryptococcus)
  - ❑ caspofungin IV (e.g., systemic infections caused by Candida)

Reauthorization: 3 months

- ❑ Provider attests renal function is being monitored and no preclusions due to toxicity have been observed
- ❑ Provider has submitted documentation to confirm the member's condition has improved or stabilized, or that continued therapy is otherwise medically necessary, and the benefits outweigh the risks (e.g., HIV)

Medication being provided by (check applicable box(es) below):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

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*: 5/25/2023**
REVISED/UPDATED: ~~7/11/2023;~~ **10/25/23**