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: Dextenza® (dexamethasone ophthalmic insert) **(J1096) (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.

❑ **Dextenza® (dexamethasone) ophthalmic insert – HCPCS codes covered if selection criteria are met:**	
J1096	4 billable units/eye (NDC 70382-204-01)
ICD-10 codes covered if selection criteria are met:	
G89.18	Other acute postprocedural pain [ocular pain following ophthalmic surgery]
H57.10 - H57.13	Ocular pain [ocular pain following ophthalmic surgery]
H10.10-H10.13	Acute atopic conjunctivitis
H10.45	Other chronic allergic conjunctivitis

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Note: When administered at the time of ophthalmic surgery, Dextenza (dexamethasone ophthalmic insert) is considered a supply integral to the surgery and is not separately reimbursed.

Dextenza is considered experimental and investigational for all other indications (e.g., panuveitis) (not an all-inclusive list) due to insufficient evidence to support the effectiveness of therapy for all other FDA unapproved indications

Recommended Dosage: Place single 0.4 mg insert into the lower lacrimal canaliculus for up to 30 days

Quantity Limits: 1 insert per eye every 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.

Authorization Criteria

- ❑ **Diagnosis: Ocular inflammation and pain following ophthalmic surgery.**

- ❑ Member has a diagnosis of ocular inflammation and pain following ophthalmic surgery
- ❑ Prescriber attests that Dextenza® will be placed by a physician immediately following ophthalmic surgery
- ❑ Date of ophthalmic surgery must be provided: _____
- ❑ A patient-specific, clinically significant reason why corticosteroid ophthalmic preparations, such as solution or suspension, typically used following ophthalmic surgery are not appropriate for the member must be provided (e.g., Cognitive (such as dementia or Alzheimer's disease) or dexterity issues prohibiting the member from using corticosteroid eye drops)
- ❑ Requested medication will **NOT** be used in members with any of the following medical conditions: active corneal, conjunctival or canalicular infections, including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, varicella; mycobacterial infections; fungal diseases of the eye, and dacryocystitis
- ❑ Provider attests member will be closely monitored for adverse reactions for the treatment of ocular inflammation and pain following ophthalmic surgery including but not limited to iritis, IOP increase, visual acuity reduction, CME, corneal edema, eye pain and conjunctival hyperemia

Authorization Criteria

- ❑ **Diagnosis: Ocular itching associated with allergic conjunctivitis.**

- ❑ Member has a diagnosis of ocular itching associated with allergic conjunctivitis

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- ❑ Member has continued to experience ocular itching associated with allergic conjunctivitis after failure of **ALL** the following unless contraindicated or intolerant:
  - ❑ Topical ophthalmic antihistamines with mast cell-stabilizing properties (e.g., azelastine, olopatadine, ketotifen, epinastine)
  - ❑ Topical ophthalmic mast cell stabilizers (e.g., cromolyn, nedocromil, lodoxamide)
  - ❑ Topical ophthalmic corticosteroid
- ❑ Requested medication will **NOT** be used in members with any of the following medical conditions: active corneal, conjunctival or canalicular infections, including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, varicella; mycobacterial infections; fungal diseases of the eye, and dacryocystitis
- ❑ Provider attests member will be closely monitored for adverse reactions for the treatment of ocular itching associated with allergic conjunctivitis including but not limited to increased IOP, increased lacrimation, eye discharge and reduced visual acuity

Reauthorization Criteria – Coverage cannot be renewed

Medication being provided by (check box below that applies):

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

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health'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: 9/15/2022**
REVISED/UPDATED/REFORMATTED: 10/31/2022