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.**

Long-Acting Injectable Atypical Antipsychotics (Non-Preferred)

Drug Requested: (select one from below)

❑ **Rykindo® IM injection** (risperidone)	❑ **Zyprexa® Relprevv™ IM injection** (olanzapine)
❑ **Erzofri® IM injection** (paliperidone palmitate)	

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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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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. **Approval: 12 months**

❑ **Patient has tried and failed at least two (2) of the following PREFERRED drugs:**

❑ Abilify Asimtufii®	❑ Abilify Maintena®	❑ Aristada®, Aristada® Initio
❑ Invega Hafyera™, Sustenna®, & Trinza®	❑ Perseris™	❑ Risperdal Consta®
❑ Uzedy™		

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.*