

# 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)

<input type="checkbox"/> Rykindo™ IM injection (risperidone)	<input type="checkbox"/> Zyprexa® Relprevv™ IM injection (olanzapine)
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**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: \_\_\_\_\_

**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**

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

<input type="checkbox"/> Abilify Asimtufii®	<input type="checkbox"/> Abilify Maintena®	<input type="checkbox"/> Aristada®, Aristada® Initio
<input type="checkbox"/> Invega Hafyera™, Sustenna®, & Trinza®	<input type="checkbox"/> Perseris™	<input type="checkbox"/> Risperdal Consta®
<input type="checkbox"/> Uzedy™	<input type="checkbox"/> Erzofri®	

***\*\*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.\****