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: Pivya™ (pivmecillinam)

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:** _____

Recommended Dosage: One tablet three times daily for 3 to 7 days as clinically indicated

Quantity Limit: 9 tablets per 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.

Length of Authorization: Date of Service

- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis uncomplicated urinary tract infections (uUTI) caused by susceptible isolates of *Escherichia coli*, *Proteus mirabilis* and *Staphylococcus saprophyticus*
- ❑ Lab cultures must show that bacteria is sensitive to Pivya **(submit documentation)**

(Continued on next page)

- ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following oral antibiotics unless intolerant or bacteria is drug resistant **(submit documentation)**:
  - ❑ sulfamethoxazole-trimethoprim
  - ❑ nitrofurantoin
  - ❑ ciprofloxacin or levoflaxacin
  - ❑ amoxicillin-clavulanate
  - ❑ cephalexin
  - ❑ cefdinir

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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: 3/26/2026**
REVISED/UPDATED/REFORMATTED: 4/16/2026