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:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy

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: 7-day approval. No renewal

- ❑ Member is 18 years of age or older
- ❑ Member is assigned female at birth

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- ❑ Member has a diagnosis of uncomplicated urinary tract infection (uUTI)
- ❑ Member has tried, or has a contraindication or an intolerance to first-line therapy or alternatives (e.g., nitrofurantoin, trimethoprim/sulfamethoxazole, fosfomycin, amoxicillin/clavulanic acid, ciprofloxacin, levofloxacin)
- ❑ Member's uUTI caused by ≥ 1 of the following susceptible microorganisms *Escherichia coli, Proteus mirabilis* or *Staphylococcus saprophyticus*
- ❑ Member has primary or secondary carnitine deficiency resulting from inherited disorders of mitochondrial fatty acid oxidation and carnitine metabolism, and other inborn errors of metabolism (e.g., methylmalonic aciduria, or propionic acidemia)
- ❑ Member does not have acute porphyria

*****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;**~~ **10/16/2026**