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: Topical Acne Drugs – Dermatologic (Non-Preferred and/or 18 Years of Age or Older)

Preferred Medications: (Combo Benzoyl Peroxide, Clindamycin, Erythromycin & other Top)				
❑ **Acne medication gel, lotion**	❑ **Benzoyl peroxide wash, cream, gel, lotion (OTC)**	❑ **clindacin ETZ 1% pledget**	❑ **clindamycin phosphate 1% solution**	❑ **clindamycin phosphate 1% pledget, swab**
❑ **Clindamycin phosphate 1% gel**	❑ **clindamycin phosphate 1% lotion**	❑ **clindamycin/ benzoyl peroxide (Duac®)**	❑ **erythromycin solution**	

Preferred Medications: (Retinoids/Combinations, Topical)	
❑ **Adapalene 0.1% gel OTC**	❑ **Tretinoin 0.025., 0.05, 0.1 % cream & 0.025% gel**

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:** _____

(Continued on next page)

Prior authorization for a cosmetic indication CANNOT be approved.
All Non-Preferred Medications and/or members 18 years of age or older Require a Prior Authorization

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.

1. Is member 18 years of age or older? **(PA is required to evaluate treatment diagnosis. Drugs are intended** for **ACNE ONLY)** ❑ Yes ❑ No

   AND

2. For **Non-Preferred** drugs, member has tried and failed at least **two (2) Preferred** drugs **from the corresponding class**. **(intended for ACNE ONLY)** ❑ Yes ❑ No

   List previous medications below **(including name of drug and dose)**:

   _____

   _____

   _____

   _____

   _____

*****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.****

REVISED/UPDATED: ~~7/6/2017~~; ~~8/23/2017~~; ~~9/1/2017~~; ~~12/26/2017~~; ~~8/31/2018~~; ~~(Reformatted) 6/21/2019; 1/14/2020; 6/28/2022; 6/26/2023; 9/26/2023;~~ **10/20/2025**