SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL 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 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Panhematin® (hemin for injection) **J1640 (Medical)**

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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.

Initial Authorization: 14 days

- ❑ Member is 16 years of age or older
- ❑ Prescribed by or in consultation with an obstetrics/gynecology specialist
- ❑ Member has a diagnosis of acute intermittent porphyria related to the menstrual cycle
- ❑ Provider has submitted documentation of elevation of urinary porphobilinogen (PBG) **AND** delta-aminolevulinic acid (ALA)

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- ❑ Initial carbohydrate therapy has been documented to be inadequate
- ❑ Requested medication dosing is prescribed in accordance with the United States Food and Drug Administration (FDA) approved labeling (1 to 4 mg/kg/day IV for 3 to 14 days; maximum: 6 mg/kg per 24 hours)

Reauthorization: 14 days. 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.

- ❑ Member has previously been receiving Panhematin
- ❑ Provider has submitted documentation which confirms member has experienced a positive response to Panhematin therapy demonstrated by clinical improvement, or by a decrease in at least **ONE** of the following compounds in urine: ALA, PBG – porphobilinogen, uroporphyrin, coproporphyrin)
- ❑ Requested medication dosing is prescribed in accordance with the United States Food and Drug Administration (FDA) approved labeling (1 to 4 mg/kg/day IV for 3 to 14 days; maximum: 6 mg/kg per 24 hours)

Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call Optima Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Optima's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

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.*